

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
The Living at Home Waiver program requests to make the following changes in this renewal application.

The waiver will begin to offer case management as a waiver service on November 1, 2009, when the existing contract for administrative case management services expires. The Department is applying for a 1915 (b)(4) waiver in order to limit service providers. LAH is requesting to increase cost neutrality to 125 percent in anticipation of increased plan of service costs resulting from this change.

A number of changes to the Living at Home Waiver Program have been implemented since the 2004 renewal application was submitted and approved by CMS. These modifications, which were implemented to increase program flexibility, were the result of stakeholder feedback and legislation. Additionally, the changes have helped improve the quality of life for LAH participants.

Waiving Certain Provider Qualifications

In 2004, LAH implemented a policy where participants, opting to use the non-agency or consumer model of attendant care, may request to waive certain requirements for provider participation including the age limit, criminal background investigation, first aid and cardiopulmonary resuscitation (CPR). The program made this change based on stakeholder feedback because some participants were interested in hiring personal care providers, some of whom were family members, long-term friends and others who served as caregivers through less restrictive personal care programs. In addition, some participants live in the same households with the informal providers and felt comfortable with that person's ability to provide care and past criminal history.

Self-Direction of Attendant Care

In 2005, the LAH Waiver implemented a consumer directed policy of attendant care "self-delegation." This policy allows cognitively capable adults who use the non-agency or consumer directed model of attendant care services to direct their caregiver without using a Nurse Monitor. These participants request to waive the requirement that a registered nurse must train and delegate to the non-agency attendants. Under this provision, the consumer takes the responsibility for hiring, training, instructing and delegating activities that are performed by the attendant as well as documenting their plan of care needs.

House Bill 218/Transfer of Waiver Administration

In 2008, the Maryland General Assembly passed HB 218 which codified the 2005 transfer of program administration from the Department of Human Resources (DHR) to the Department of Health and Mental Hygiene. In addition to a number of minor changes and clarifications, this legislation expanded the program's upper age limit, upon enrollment, from 59 to 64, making the population served from 18-64 upon enrollment. The program continues to serve individuals enrolled throughout their life span.

New Waiver Services

DHMH submitted an amendment to CMS to add new services to the waiver effective July 1, 2008: Medical Day Services, Environmental Assessments, Dietician and Nutrition Services and Home Delivered Meals.

Employed Individuals with Disabilities

DHMH submitted an amendment to CMS to request to expanded financial eligibility to include individuals who qualify for Medicaid through the EID program. This program is available in Maryland and is in accordance with the Ticket to Work and Work Incentives Improvement Act and has an October 1, 2008 effective date.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A. The **State of Maryland** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. **Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Living at Home Waiver Program
- C. **Type of Request:** renewal
- ☐ **Migration Waiver** - this is an existing approved waiver
- ☒ **Renewal of Waiver:**
 Provide the information about the original waiver being renewed
- Base Waiver Number:** 0353
- Amendment Number**
 (if applicable):
- Effective Date:** (mm/dd/yy) 04/01/01
- Waiver Number:** MD.0353.R02.00
- Draft ID:** MD.09.02.00
- Renewal Number:** 02
- D. **Type of Waiver** (*select only one*):
 Regular Waiver
- E. **Proposed Effective Date:** (mm/dd/yy)
 07/01/09

1. Request Information (2 of 3)

- F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):
- ☐ **Hospital**
 Select applicable level of care
- ☐ **Hospital as defined in 42 CFR §440.10**
 If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
- ☐ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**
- ☒ **Nursing Facility**
 Select applicable level of care
- ☒ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**
 If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
 Not applicable
- ☐ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR level of care:

1. Request Information (3 of 3)

- G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities
Select one:

☐ **Not applicable**☒ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

LAH will be submitting a 1915 (b)(4) waiver application to limit case management providers for the waiver program.

Specify the §1915(b) authorities under which this program operates (*check each that applies*):☐ **§1915(b)(1) (mandated enrollment to managed care)**☐ **§1915(b)(2) (central broker)**☐ **§1915(b)(3) (employ cost savings to furnish additional services)**☒ **§1915(b)(4) (selective contracting/limit number of providers)**☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**☐ **A program authorized under §1915(j) of the Act.**☐ **A program authorized under §1115 of the Act.**

Specify the program:

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Living at Home Waiver(LAH) program is designed to provide cost-effective Home and Community Based Medicaid Waiver Services to adults with physical disabilities who are enrolled between the ages of 18 and 64 years. LAH services are offered to participants as an alternative to institutional care in a nursing facility. The goals of the waiver are to provide quality services for individuals in the community, ensure the well-being and safety of the participants and to increase opportunities for for self-advocacy and self-reliance.

Objectives for this waiver renewal include enhancing service delivery through improving outcome-based quality assurance systems. In addition, improving quality in nurse monitor services.

The organizational structure:

The Department of Health and Mental Hygiene (DHMH), Office of Health Services (OHS) has full administrative authority over the LAH Waiver Program, located within the Living at Home Waiver Division. The Unit is supervised by the LAH Division Chief who reports to the Deputy Director for Long Term Care and Waiver Services in the OHS.

Applicants must meet a nursing level of care (LOC)in order to meet medical criteria for participation in the program. The initial and

annual LOC determination is made by the Department's contracted Utilization Control Agent after receiving evaluation information and other requested documents. The UCA Contract Monitor conducts regular reviews to ensure that LOC determinations are completed according to regulatory requirements. In order to participate in the waiver program, applicants must also meet technical (age) and financial eligibility.

Participants are offered an array of waiver, State Plan Medicaid and community supports and services. As part of their initial and an annual eligibility determination, applicants and participants receive case management services. The LAH Waiver Division is responsible for the daily waiver administration including maintaining and monitoring a contractor to provide case management services. Case Managers serve as agents of the Department that are responsible for assisting participants with eligibility determination, accessing all waiver, non-waiver services, benefits and entitlements needed to maintain healthy and safe community living. Program participants and/or their representative are actively involved in working with case managers in order to make informed decisions about waiver services and providers. Each participant is able to choose between consumer-directed or agency based attendant care services. Each participant and/or their representative reviews, signs and receives a copy of their plan of service. Case managers actively engage participants for on-going decision-making about model of attendant care, provider choice, provider schedule, and other service delivery options. Case Managers are responsible for documenting information in a web-based tracking system as well as reporting critical events, incidents and complaints through the Department's "Reportable Events" Policy and Procedure. They are also responsible for monitoring cost neutrality for each participant.

The LAH Waiver Division staff approve services plans and monitor cost neutrality. Division staff maintain a reportable events/complaints data-base. LAH staff analyze reportable event/complaint data and generate reports. The reports are shared with and evaluated by the Quality Waiver Council which is comprised of representatives from all of the 9 home and community-based services waivers and other agency representatives.

Providers must meet waiver conditions of participation based on provision of services and are required to submit an application with other requested documentation to LAH staff. Staff are responsible for certification and enrollment of providers as well as on-going review of provider credentials and requirements. Many providers must also meet licensure requirements mandated by the State's Office of Health Care Quality.

Division staff also maintain and monitor a contractor that performs fiscal intermediary (FI) services for participants employing attendant care providers through the consumer-directed model. LAH staff routinely review claims and evaluate FI reports and other pertinent documents.

The DHMH, OHS, Division of Evaluation and Quality Care Review (QCR) has a team of professionals including registered nurses and social workers who conduct annual on-site visits, observations, and interviews and record reviews of a random sample of LAH participants. These reviews are conducted to ensure the health, welfare, and safety of waiver participants. The QCR Team evaluates program services/satisfaction and/or identifies issues which may require a plan of correction by the providers and a procedural or system change.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

☒ **Yes. This waiver provides participant direction opportunities.** Appendix E is required.

☐ **No. This waiver does not provide participant direction opportunities. Appendix E is not required.**

- F. Participant Rights. Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards. Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy. Appendix H** contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability. Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration. Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

☐ **Not Applicable**

☐ **No**

☒ **Yes**

- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

☒ **No**

☐ **Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

- ☐ **Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community- based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
The Living at Home Waiver Program has established an advisory committee that meets five times per year. This group is comprised of waiver participants and providers, community advocates, contractual representatives and Office of Health Services staff. This group discusses waiver activities and areas where modifications are requested.

In addition, public input about the waiver has been obtained through the Money Follows the Person (MFP) demonstration grant stakeholder group. The MFP project also held smaller work groups to address areas where changes to the waiver were recommended. One area of interest was improving waiver participant's ability to access behavioral health supports in the community. This area will be further explored during the first year of the LAH waiver renewal and recommendations will be included in the first annual report.

In preparation for the waiver renewal, LAH staff sent a mailing to all waiver participants and/or their designees in an attempt

to solicit feedback. Participants and/or their designees were offered a choice between providing feedback through a regional focus group, an individual in-home meeting, an online survey tool, a telephone survey or a survey to be completed via mail. The case manager assigned to each participant then followed up to determine if individuals were interested in providing feedback and their preferred method of doing this. Approximately forty-five percent of the program participants or their designated representatives did not respond or responded that they are not interested in providing input at this time; approximately fifty-five percent expressed interest in participation.

The greater Baltimore region was affirmative about participating in a focus group and two participants were sought to co-facilitate the meeting.

- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Maryland

Zip: 21201

Phone: (410) 767-4003 **Ext:** ☐ TTY

Fax: (410) 333-6547

E-mail: beman-pearsalla@dhmh.state.md.us

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Sandra Brownell
State Medicaid Director or Designee

Submission Date: Apr 1, 2009

Last Name: Folkemer

First Name: John

Title: Deputy Secretary for Health Care Financing

Agency: Department of Health and Mental Hygiene

Address: 201 West Preston Street

Address 2:

City: Baltimore

State: Maryland

Zip: 21201

Phone: (410) 767-4139

Fax: (410) 333-7687

E-mail: folkemerj@dhmh.state.md.us

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Not applicable

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- ☒ The waiver is operated by the State Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- ☒ The Medical Assistance Unit.

Specify the unit name:

The Office of Health Services

(Do not complete item A-2)

- ☐ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- ☐ The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (Complete item A-2-b).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this

section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- ☒ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
The Living at Home Waiver Division monitors contractual services delivered to waiver participants for case management and fiscal intermediary services.

Case Management

The contracted case management agency assists applicants and participants with initial and annual eligibility determination as well as coordinate services required for healthy and safe community living. The contracted case management agency is required to submit monthly and quarterly reports about critical incidents and events. This agency is responsible for analyzing service utilization based on claims data provided by the LAH Waiver Division. Case managers are required to administer transition services for participants enrolling in the waiver from nursing facilities. Beginning in 2008, the LAH waiver implemented the use of a web based application and tracking system which case managers use to track the eligibility process or other time sensitive activities. Several reports are being built into the tracking system which will allow the LAH staff to have real time access to information about eligibility determination and case status.

Fiscal Intermediary Services Contract

Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants; in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers' compensation. The contract is monitored by the Agency Budget Specialist in the Living at Home Waiver Division.

Utilization Control Agent

The Office of Health Services in the Department of Health and Mental Hygiene contracts with a Utilization Control Agent (UCA) which is responsible for determining medical eligibility for programs that require a nursing facility level of care. The UCA is responsible for making medical level of care determinations for initial and annual evaluations for the Living at Home Waiver Program.

- ☐ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- ☐ **Not applicable**
- ☒ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- ☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

Adult Evaluation and Review Services

The Adult Evaluation and Review Services or AERS refers to a program operated by local health departments (LHDs) of Maryland's 24 political subdivisions. The Office of Health Services has a Memorandum of Understanding with the local departments for the purpose of providing payment for comprehensive long term care evaluations. The AERS staff include registered nurses, licensed social workers, and other members of a multi-disciplinary team who conduct comprehensive evaluations which addresses the following areas: medical/nursing, functional, psycho-social and environmental assessments for individuals at risk of institutionalization. The team assists the individual, family, personal physicians and others by developing an appropriate plan of care to help the patient remain in the least restrictive environment. After developing a recommended plan of care, AERS provides a copy of their evaluation and recommendations to the contracted case management agency. Generally, the AERS staff conduct the initial and annual comprehensive evaluations for applicants and participants. AERS does not provide treatment.

The Hilltop Institute

The Hilltop Institute, formerly the Center for Health Programs and Data Management, located at the University of Maryland Baltimore County has a Memorandum of Understanding with the Department of Health and Mental Hygiene. Under this MOU, the Hilltop Institute collects, analyzes and reports on program information/data. The Hilltop Institute is responsible for developing and maintaining the LAH tracking system. In addition, this agency is responsible for backing up program data and ensuring secure storage for all program information. The Hilltop Institute developed and maintains the Quality Care Review Team web-based tracking system which can access pertinent data from the LAH tracking system. The QCRT tracking system collects and analyzes LAH waiver review data and generates findings reports.

- **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

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Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Office of Health Services in the Department of Health and Mental Hygiene monitors the performance of all contracts.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Office of Health Services in the Department of Health and Mental Hygiene monitors the performance of the following contracts:

The Utilization Control Agent Contract is managed under the Division of Long Term Care Services. The activities of the UCA are monitored by the Chief of the Division of Long Term Care Services. The contract monitor for the UCA contract

completes quarterly reporting to determine if the Level of Care tool (the 3871B form) was used appropriately and if accurate determinations were made as a result. This information is compiled into a UCA LOC report and analyzed. Actions are taken based on the analyzed data.

The contracted case management agency is monitored by staff in the Living at Home Waiver Division. The case management contract is monitored by the Medical Care Program Specialist in the Living at Home Waiver Division. The case management agency is required to submit monthly invoices, summary activity reports, reports of complaints, incidents and critical events. This entity submits quarterly reports on participant service utilization and quality measures including monitoring activities. In addition, this contractor is required to perform monthly contacts, and quarterly face-to-face visits with program applicants and participants. LAH staff perform site visits to monitor the agency record keeping and adherence to program policies and procedures. Reporting on these findings is compiled on a quarterly basis. The LAH Waiver Division implemented the use of a participant tracking system in 2008; future monitoring of routine activities and time frames for eligibility determination completion will be completed through reports that are built into the tracking system.

The case management contractor must meet with the LAH Waiver Division monthly for the purpose of ongoing communication and technical assistance. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly. In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

Appendix A: Waiver Administration and Operation

- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Completion of an annual report beginning in March, 2010. LAH will compile an annual HCBS Waiver Review Report including statistics on enrollment, demographics, annual cost, service utilization, distribution of costs for waiver and State Plan Medicaid services, performance on quality measures, remediation initiatives, system design improvements, stakeholder recommendations and overall trends.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Reports from the LAH Tracking System and Case Management, LAH Advisory, Money Follows the Person Stakeholders (through 2011) and Annual Participant Focus Group meetings. The annual QCR Team report.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CM and FI Contractors QCR Team	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Hilltop Institute	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percentage of providers who receive training. LAH will require training for Nurse Monitor and Attendant Care providers for regulation changes by 2011. Numerator: Number of provider agencies who receive training. Denominator: Number of Provider Agencies currently working with LAH participants.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Provider Service Reports, Reportable Events, Participant feedback, case manager documentation

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Percentages of Plans of Service (POS) approved prior to accessing services. Numerator: Number of POS approved in advance of service delivery. **Denominator:** Total number of POS completed.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Record reviews completed in the LAH Tracking System.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Percentage of Plans of Service within required limits. Numerator: Total number of POS above 100% of cost neutrality. **Denominator:** Total number of approved POS for enrolled participants.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

LAH tracking system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Percentage of Qualified Providers Who Are Enrolled To Provide Waiver Services. Numerator: Number of Providers who are enrolled annually to provide services. **Denominator:** Total number of provider applications received at the Living at Home Waiver Division.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Provider database

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Percentage of applicants and participants who are evaluated for Level of Care annually.

Numerator: Total number of LAH Level of Care determinations completed annually.

Denominator: Total number of waiver applicants and participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

LAH Tracking System

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percentage of applicants who receive 85% or more of services identified in their waiver plan of service (POS) annually. Numerator: Number of LAH participants receiving 85% or more of waiver services annually. Denominator: Number of LAH waiver participant receiving services annually.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Electronic Billing System

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

<input type="checkbox"/> Other Specify: <input type="text"/>

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

The Office of Health Services will issue correspondence to enrolled LAH providers regarding rates and methodology no less than annually.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Rate methodology is defined in COMAR at 10.09.55.29 C(4)

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: N/A
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percentage of applications with eligibility determinations completed within 60 days of the date of the application. Numerator: Number of initial eligibility determinations completed within 60 days of the date of the application. Denominator: Number of applications completed annually.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

LAH Tracking System report will provide information on a monthly basis beginning in April 2009

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

LAH will complete a waiver amendment prior to June 30th of each year of the waiver renewal when additional slots need to be requested.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

LAH Tracking System is used to collect data about enrollment statistics.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Annual Completion of the Quality Care Review Team Survey. The Office of Health Services Quality of Care Review Team will conduct an annual review of a sample of LAH participants and require corrective and preventative action plans (CAPAs) for deficiencies. LAH and/or contractors will respond to the QCR Team findings by completing CAPAs and updating the Quality Plan.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 5% sample
	<input type="checkbox"/> Other	

	Specify:	
	<input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted CM	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

RE Complaints

Email

Calls

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Individual participant and provider problems are identified through reportable events, complaints, case notes, provider service reports, provider claims and other sources. When program issues are identified, the LAH Waiver Division will refer the problem to the individual assigned to that area (see title and function list below). Generally, the staff person will immediately identify the impact of an issue.

Generally, issues are referred to staff for resolution as follows:

Quality of Care Issues to include reportable events, critical incidents, complaints, neglect, abuse, service delivery interruption-Quality Assurance Specialist, Medical Program Supervisor and Division Chief

Application Processing or issues of timely processing-Nursing Facility Specialist and Division Chief

Re-evaluation for continued eligibility-Participant Specialist and Medical Care Program Supervisor

Provider Enrollment, Credentialing, Capacity-Provider Specialist and Medical Care Program Specialist

Claims Payment, Fiscal Intermediary Issues-Agency Budget Specialist, Medical Care Program Associates

Tracking System Issues-Quality Assurance Specialist

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each of the subgroups in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="radio"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input type="checkbox"/>	Disabled (Other)	<input type="text"/>	<input type="text"/>	
<input type="radio"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="radio"/> Mental Retardation or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

	<input type="checkbox"/>	Mental Retardation	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input checked="" type="radio"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness	<input type="text"/>	<input type="text"/>	
	<input type="checkbox"/>	Serious Emotional Disturbance	<input type="text"/>	<input type="text"/>	

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Individuals must meet nursing facility level of care standard in Maryland, have a waiver plan of service that includes all waiver and state plan services. Individuals must have a waiver plan of service that is within the State cost neutrality guidelines and includes all services necessary to meet the health and safety needs of the individual in a community setting. All participants must choose to receive services in the community versus a nursing facility or other location.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

If enrolled by age 64, Living at Home Waiver participants may remain in the program throughout their life span as long as they continue to meet eligibility requirements. Applicants who are within six months of age 64 are notified about resources that are available through Maryland's Home and Community Based Services Waiver for Older Adults as well as other regional resources that may be accessed through the Area Agencies on Aging or Commission on Aging.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ☐ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☒ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- ☒ A level higher than 100% of the institutional average.

Specify the percentage:

- ☐ Other

Specify:

- ☐ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ☐ **Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

- ☐ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

- ☐ **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- ☐ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

- ☐ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Each LAH applicant is assessed by the Adult Evaluation and Review Services staff, located in the local health departments offices throughout the State. This entity completes a medical and social evaluation of the applicant, including a complete record review, and makes recommendations about the type, frequency and duration of any services necessary to ensure

healthy and safe community living. This evaluation is forwarded to the case manager assigned to work with the applicant. The case manager reviews the AERS recommended plan of care and other documents with the applicant; together they develop a plan of services including all services to live safely in the community. The case manager's plan of services may differ from the recommendations made by AERS in that the applicant may choose some informal care, or a different service to meet a specific need.

After the plan of services is completed by the case manager, it is forwarded to the Living at Home Waiver Division for approval. Each plan is reviewed to ensure that it includes all necessary services or another indication of how needs will be met as well as the program's cost limit. In situations where the plan of services exceeds the 125% cost limit, the LAH Waiver Division works closely with the case management agency to troubleshoot available options; applicants are denied in cases where the plan of services cannot be brought within the program cost limits.

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
☒ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Services may be approved if they are within 100% and 125% of the annual cost neutrality amount in certain circumstances. These services are approved based on recommendations by the Adult Evaluation and Review Services, the contracted case management agency and the applicant. The LAH Waiver Division considers the degree of assistance an individual needs to live safely in the community, the availability of other resources to meet the individual's needs and any informal supports that may exist when making the decision to approve plans of service in this range.

In addition, the program policy is also based on LAH participants requiring varying amounts of services. Plans of service that cost up to 125% of cost neutrality must be balanced by plans of service that are below 100% of cost neutrality. The Living at Home Waiver Division Fiscal Unit generates quarterly reports of plan of service costs, based on actual paid claims, in order to monitor the plan costs.

Program trends inform that a high percentage of individuals transitioning to the community from nursing facilities require initial expenditures to facilitate a safe discharge. These items tend to be high dollar durable medical equipment for mobility, such as wheelchairs, funds for environmental accessibility adaptations including ramps, assistive technology expenses for environmental controls and transitional services. Conversely, other program trends show that many individuals have static costs that vary only when their informal supports change or progressive conditions become worse.

- ☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	765

Year 2	850
Year 3	944
Year 4 (renewal only)	1047
Year 5 (renewal only)	1162

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

- ☒ The State does not limit the number of participants that it serves at any point in time during a waiver year.
- ☐ The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. **Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

- ☒ Not applicable. The state does not reserve capacity.
- ☐ The State reserves capacity for the following purpose(s).

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

- d. **Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

- e. **Allocation of Waiver Capacity.**

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.

☒ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

In December of 2002 the Living at Home Waiver Program closed to new community applicants due to a lack of funding for new community applicants. In 2001, the State passed legislation HB 946 and SB 620, also informally known as the Money Follows the Individual Accountability Act. Based on this legislation, Maryland continues to allow eligible applicants from Nursing Facilities to apply for the LAH Waiver Program provided they reside in a Maryland Nursing Facility and their services are funded by Medicaid for 30 or more days. When LAH serves more individuals than approved by CMS through the application process, an amendment is submitted to CMS requesting approval for additional slots.

When funds become available as a result of legislation or the annual budget process, the LAH waiver will be able to accept additional community applications. When such funding is available, LAH accesses potential applicants from the program interest list, the Waiver Services Registry, in the order in which their names were placed on the list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a.**
- 1. State Classification.** The State is a (*select one*):
 - ☒ §1634 State
 - ☐ SSI Criteria State
 - ☐ 209(b) State
 - 2. Miller Trust State.**
Indicate whether the State is a Miller Trust State (*select one*):
 - ☒ No
 - ☐ Yes
- b. Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☒ Low income families with children as provided in §1931 of the Act
- ☒ SSI recipients
- ☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
- ☒ Optional State supplement recipients
- ☐ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☐ 100% of the Federal poverty level (FPL)
- ☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
- ☒ Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
- ☐ Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- ☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- ☐ Medically needy in 209(b) States (42 CFR §435.330)
- ☒ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- ☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

Section 1931 Families terminated from AFDC/TCA because of increased earnings or hours of employment (42 CFR §435.112)

Section 1931 Individuals who lose TCA due to child or spousal support (1902(a)(10)(A)(i)(I)406(h).

Individuals who meet the income and resource requirements of the cash assistance programs up to 116% of FPL(42 CFR §435.210).

Optional Coverage of Medically Needy (42 CFR §435.301)

Pregnant and post partum women with income at or below 185% of FPL [1902(a)(10)(A)(i)(IV)and 1902 (l)(1)(A) and (B)].

Pregnant and post-partum women with income more than 185% FPL and at or below 250% FPL [(1902(a)(10)(A)(ii)(IX) and 1902(l)].

Individuals who become ineligible for cash assistance as a result of OASDI cost of living increases after 1977 (42 CFR §435.135)

Section 5103 OBR Act- Widows and Widowers who lost SSI eligibility because of a change in the federal disability definition.

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- ☐ No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
- ☒ Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

- ☐ All individuals in the special home and community-based waiver group under 42 CFR §435.217
- ☒ Only the following groups of individuals in the special home and community-based waiver group under 42

CFR §435.217*Check each that applies:*☒ **A special income level equal to:***Select one:*

- ☒ **300 % of the SSI Federal Benefit Rate (FBR)**
☐ **A percentage of FBR, which is lower than 300 % (42 CFR §435.236)**

Specify percentage:

- ☐ **A dollar amount which is lower than 300 %.**

Specify dollar amount:

- ☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
☐ **Aged and disabled individuals who have income at:**

Select one:

- ☐ **100 % of FPL**
☐ **% of FPL, which is lower than 100 %.**

Specify percentage amount:

- ☐ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

*Specify:***Appendix B: Participant Access and Eligibility****B-5: Post-Eligibility Treatment of Income (1 of 4)**

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- ☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a**

community spouse for the special home and community-based waiver group.

In the case of a participant with a community spouse, the State elects to (*select one*):

- ☒ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)
- ☐ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)
- ☐ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State) . Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

The State uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ☒ **The following standard included under the State plan**

Select one:

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☒ **The special income level for institutionalized persons**

(*select one*):

- ☒ **300% of the SSI Federal Benefit Rate (FBR)**
- ☐ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ☐ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ☐ **A percentage of the Federal poverty level**

Specify percentage:

- ☐ **Other standard included under the State Plan**

Specify:

- ☐ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ **The following formula is used to determine the needs allowance:**

Specify:

- ☐ **Other**

Specify:

ii. Allowance for the spouse only (select one):

- ☐ **Not Applicable**
- ☐ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (select one):

- ☐ **SSI standard**
- ☐ **Optional State supplement standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

- ☐ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (select one):

- ☐ **Not Applicable (see instructions)**
- ☐ **AFDC need standard**
- ☐ **Medically needy income standard**
- ☐ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

- ☒ **The amount is determined using the following formula:**

Specify:

- ☒ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☒ **Not Applicable (see instructions)** *Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- ☐ **The State does not establish reasonable limits.**
- ☐ **The State establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(select one):

- ☐ SSI standard
- ☐ Optional State supplement standard
- ☐ Medically needy income standard
- ☒ The special income level for institutionalized persons
- ☐ A percentage of the Federal poverty level

Specify percentage:

- ☐ The following dollar amount:

Specify dollar amount: If this amount changes, this item will be revised

- ☐ The following formula is used to determine the needs allowance:

Specify formula:

- ☐ Other

Specify:

- ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ☒ Allowance is the same
- ☐ Allowance is different.

Explanation of difference:

- iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses.

Select one:

- ☒ **Not Applicable (see instructions)** Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.
- ☐ The State does not establish reasonable limits.
- ☐ The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- ☐ The provision of waiver services at least monthly
☒ Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Current program regulations require a program participant to use at least one waiver service annually in order to maintain program eligibility. Case managers are required to monitor program participants monthly through contacts and quarterly via face-to-face visits.

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (select one):

- ☐ Directly by the Medicaid agency
☐ By the operating agency specified in Appendix A
☒ By an entity under contract with the Medicaid agency.

Specify the entity:

The Department's contracted Utilization Control Agent (UCA) is responsible for initial and annual evaluations of Level of Care based on assessment information obtained by the Adult Evaluation and Review Service staff of the local health departments. Registered Nurses employed by the UCA review the documentation in order to make a determination. Any denied level of care decision for a Living at Home Waiver participant is reviewed by the Medical Director of the UCA and a Medicaid physician advisor as needed.

- ☐ Other
Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

The UCA employs licensed registered nurses to determine LOC. The UCA employs a physician as does DHMH who will assist in the determination of LOC when there are unusually complex or contested decisions made by the nurse reviewers. All LOC determinations are subject to the review and approval by the Medicaid agency.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Maryland Medicaid 3871B instrument is used to determine if an individual requires a nursing facility level of care. Individuals approved for a nursing facility level of care do not require hospital care, but have been determined to need

supervision of licensed health care professionals as a result of mental or physical status; they may require skilled nursing care, rehabilitation services, health-related care and services, above room and board, on a regular basis, as well as related services. In addition, in July of 2008 updated guidance about interpreting Level of Care criteria were sent out to Medicaid providers.

In order to receive Medicaid benefits for services in a nursing facility or through the Living at Home Waiver, an individual must meet certain medical eligibility criteria. The bases for these criteria are set forth in both federal and State regulations. In interpreting these regulatory criteria, the Program will use the following guidelines. Nursing facility services are services provided to individuals who, because of their mental or physical condition, require 1) skilled nursing care and related services, 2) rehabilitation services, or 3) on a regular basis, health-related services above the level of room and board. These services are not intended to supplant services that are provided by a hospital, IMD, or ICF/MR.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- ☒ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ☐ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The case management agency refers applicants and participants to the Adult Evaluation and Review Service program in the local health department to complete evaluations and re-evaluations for medical eligibility.

For initial evaluations and re-evaluations, the Adult Evaluation and Review Service (AERS) meets with the applicant or participant to request their permission to complete an evaluation for the Living at Home Waiver Program. After receiving consent, the AERS reviewer completes a record review and completes documentation, including the Maryland Medicaid 3871 B form. After completing this paperwork, AERS submits the 3871B documentation electronically to the contracted Utilization Control Agency for level of care determination. For initial applicants residing in nursing facilities, the AERS evaluator contacts the UCA for the most recent continued stay review dates that verify that the nursing facility level of care standard is met.

In July of 2008, DHMH began using a secure web-based participant tracking system to communicate information between agencies responsible for completing any portion of the initial or annual eligibility process. Presently, the AERS units use the Living at Home tracking system to submit level of care determination requests to the UCA.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- ☐ **Every three months**
- ☐ **Every six months**
- ☒ **Every twelve months**
- ☐ **Other schedule**

Specify the other schedule:

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- ☒ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ☐ **The qualifications are different.**

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Until July of 2008, the Living at Home Waiver Division maintained an Access database and a spreadsheet to track annual redetermination information. In addition, the contracted case management entity maintains a separate tracking system for the purpose of ensuring timely redetermination.

In July of 2008, the Living at Home Waiver Division implemented an automated tracking system. This tracking system sends alerts to case managers 60 days prior to a participant reevaluation so that the process can begin. Reports are printed for DHMH staff so that they can track reevaluations to ensure they are timely.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The Living at Home Waiver Division maintains hard copies of all evaluation and re-evaluation documentation for program applicants and participants on-site for five years. The contracted case management agency is also held to this same requirement. In addition, in July of 2008, the Living at Home Waiver Division implemented the use of a web-based tracking system that will house electronically retrievable documentation of eligibility determinations.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance:** *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Level of Care Determinations for community applicants for LAH will be completed by the UCA within 15 days of the date of referral. Numerator: Number of LOC determinations made for community applicants within 15 days of the date of referral. Denominator: Number of community applicants annually.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Utilization Control Agent	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Level of Care determinations for individuals referred to LAH Waiver Program from nursing facilities will be confirmed within 15 days of the date of program referral.
Numerator: Number of level of care confirmations completed within 15 days of applications (annually). **Denominator:** Number of annual nursing facility applicants.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation	Frequency of data collection/generation	Sampling Approach (check each that applies):
--	---	--

(check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

All LAH program participants receive an annual Level of Care redetermination by the UCA. The contracted case management agency is responsible for initiating this process 60 days prior to the participant's annual waiver enrollment date by submitting a referral to AERS via the tracking system. Numerator:# of LOC determinations completed
Denominator: # of enrolled participants.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: Contracted Case Management Agency	<input checked="" type="checkbox"/> Annually

☒ Continuously and Ongoing

☐ Other

Specify:

- c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

On a quarterly basis, the Office of Health Services monitors a sample of LOC determinations to ensure that an appropriate determination was made. Numerator: # of LOC appropriate determinations Denominator: # of LOC determinations sampled

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

As part of the initial and annual certification process, some individuals are found to no longer meet the medical eligibility criteria as determined by the level of care instrument. LAH participant's are provided written notice of the ineligibility determination and information regarding appeal rights is included. Unless a timely appeal is filed, the waiver participant is disenrolled from the program by DHMH. DHMH collects aggregate data on waiver disenrollments due to medical eligibility. If trends or patterns are discovered the DHMH investigates the medical eligibility procedures to determine if changes are needed.

ii. Remediation Data Aggregation**Remediation-related Data Aggregation and Analysis (including trend identification)**

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Each Living at Home Waiver applicant meets with a case manager from the contracted case management agency to complete a waiver application and other program paperwork. At the initial applicant meeting, the case manager is required to review the "Freedom of Choice" form indicating whether the applicant chooses, the "nursing facility," "the Living at Home Waiver program," or "Neither" option. Original signed "Freedom of Choice" forms are maintained at the office of the contracted case management agency for review, upon request, by the Living at Home Waiver Division. Information about the completion of these forms is communicated via the Living at Home tracking system.

The case managers also provides applicants or potential applicants with detailed information about the services available under the waiver as well as resources and other services that may be available to meet their ongoing needs in the community.

- b. **Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the "Freedom of Choice" forms are available via the contracted case management agency for a minimum of five years. In addition, the Living at Home Waiver Program tracking system collects data about the completion of the "Freedom of Choice" form for reporting purposes.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The State provides meaningful access to individuals with Limited English Proficiency (LEP) who are applying for or receiving Medicaid services. Methods include providing interpreters at no cost to clients, and translations of forms and documents. Additionally, interpreter resources are available for individuals who contact DHMH for information, requests for assistance or complaints. LEP services are also available via program contractors.

The DHMH website contains useful information on Medicaid waivers and other programs and resources. The website will translate this information into a number of languages that are predominant in the community. The State also provides translation services at fair hearings if necessary. If an LEP appellant attends a hearing without first requesting services of an interpreter, the administrative law judge will not proceed unless there is an assurance from the appellant that they are able to sufficiently understand and participate in the proceedings. If not, the hearing will be postponed until an interpreter has been secured.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. **Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Attendant Care
Statutory Service	Initial and Ongoing Case Management Services
Statutory Service	Medical Day Care
Other Service	Assistive Technology
Other Service	Consumer Training
Other Service	Dietitian Nutrition Services
Other Service	Environmental Accessibility Adaptation
Other Service	Environmental Assessment
Other Service	Family Training
Other Service	Home Delivered Meals
Other Service	Non-Agency Family Training
Other Service	Non-Agency Nursing Supervision
Other Service	Nursing Supervision
Other Service	Personal Emergency Response System-Monitoring
Other Service	Personal Emergency Response System-Purchase
Other Service	Transition Services

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Attendant Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service may include assistance with preparation of meals, shopping and housekeeping. Personal care providers must meet State standards for this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Waiver attendant care services may not exceed 23 hour

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☒ Legally Responsible Person
- ☒ Relative
- ☒ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Public or Private
Individual	Non-Agency Attendant Care

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care****Provider Category:**

Agency

Provider Type:

Public or Private

Provider Qualifications**License** (*specify*):

The following health professionals providing services under this chapter shall be licensed to practice in the jurisdiction in which services are: Physicians; Registered nurses; Occupational therapists; Physical therapists; Speech pathologists; Nutritionists; and Dietitians.

A license shall be provided by a Medicaid home health agency provider

Certificate (*specify*):

The following providers shall be appropriately licensed, certified, or approved by the Department to provide services: Licensed home health agency, Certified residential services agency, Medicaid personal care provider, In-home aide program, Medical day care provider, residential services agency, in-home aide program and

Medicaid Personal Care Provider Agency

Other Standard (*specify*):

Be a licensed home health agency, a certified residential services agency, Medicaid personal care provider agency, a Medicaid in home aide program (e.g. local health department), or a public or private agency which employs in-home attendants and has been approved by the Dept. of Human Resources and enrolled with the Medicaid program to provide attendant care services.

Employ or contract with attendants who meet the minimum standards of individual providers as described below.

Employ or contract with attendants in sufficient numbers to ensure that a qualified attendant is available to provide the type of attendant care services noted in and according to the schedule specified in the waiver plan of care for each waiver participant served by the agency.

Employ or contract with licensed registered nurses who meet the minimum standards for providers of skilled nursing services such as; to serve as nurse monitors for agency attendants; in sufficient numbers to ensure that a nurse is available to provide the necessary type and frequency of nursing monitoring required by each waiver participant served by the agency.

Keep accurate records which contain the waiver plan of care, attendant care service plan, nurse monitor's instructions, identification of each attendant providing services to recipients, days and times worked, tasks performed, and progress notes and observations on the attendant and the recipient.

Keep records and submit reports as required by the Department.

Maintain 24-hour availability by beeper.

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver Division

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Attendant Care****Provider Category:**Individual **Provider Type:**

Non-Agency Attendant Care

Provider Qualifications**License (specify):**

To participate in the Living at Home Waiver Program as a provider of attendant care services, unless otherwise exempted under §F of this regulation, an attendant shall: Be a consumer-employed or agency-employed attendant; Be at least 18 years old;

Be legally eligible for employment rendering attendant care services in the State; Be able to communicate, read, write, and follow directions in English; Be currently certified from a nationally recognized organization in the following areas: Cardiopulmonary resuscitation; and Basic first aid.

Certificate (specify):

Certified Nursing Assistant

Certified Medication Assistant or Certified Medication Technician

Other Standard (specify):

Individual providers of attendant care must self-employed or employed by or under contract with an attendant care provider agency. At least 18 years old. (Minors aged 14 through 17 may participate with a work permit. Minors under the age of 14 may not be employed.) *May not be the participant's spouse. *Be able to speak, read, write and follow directions in English. (The attendant must speak the primary language of the waiver participant and be able to communicate with the case manager, nurse monitor and physician.)

*Cannot render services to any participant before being evaluated by a nurse monitor. Agree to accept instructions and training from the waiver participant, the Case Manager, the Case Management Agency nurse, the designated nurse monitor, other involved professionals, or representatives of the Medicaid Single State Agency, and, in the case of delegated nursing duties, from the designated nurse monitor, the Case Management, Agency nurse, or a treating physician.

*Cannot have been convicted of a crime in accordance with COMAR 10.09.55.

If the attendant performs delegated nursing functions, the attendant must meet the requirements of the Maryland Board of Nursing regarding training in medication administration and/or delegated nursing functions, as appropriate, according to COMAR 10.27.01.

*Be currently certified in Cardiopulmonary Resuscitation and Basic First Aid and maintain those certifications.

*Note: Participants may waive these specific attendant care requirements under certain circumstances. The "waived requirement" attendants are precluded from providing services to any other program participants.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Living at Home Waiver Division

Frequency of Verification:

Upon Enrollment

On-going credentials

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Initial and Ongoing Case Management Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☒ Service is not included in the approved waiver.

Service Definition (Scope):

The most basic function of waiver Case Management is to assist with initial and annual eligibility determination for program services. In addition, LAH recognizes that waiver applicants and participants need a assistance in meeting a number of non-Medicaid needs. These needs may include the coordination of all health needs, including those for mental health, cognitive rehabilitation, and substance abuse that may be covered by Medicare, private insurers, and other community based programs. Case Management is responsible for completing the initial and annual eligibilty process, assisting with obtaining and maintaining all public and private benefits and entitlements available to the individual. The Case Management Service provider is responsible to engaging applicants, participants, and/or representatives in developing and implementing cost effective plans of service that meet the individual's preferences, as well as health and safety in the community. The Case Management Service provider is responsible for engaging participants and/or representatives in coordinating receipt of all waiver and non-waiver community services identified in the applicant or participant's plan of services for the following needs: medical, mental health, substance abuse, cognitive or physical rehabilitation, housing, physical environment, social, educational, vocational, legal (this list is not all inclusive)

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The limits of this service are identified in the applicant or participant's plan of service and may not exceed the maximum cost neutrality.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Initial and Ongoing Case Management Services

Provider Category:Agency **Provider Type:**

Case Management

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

LAH is pursuing a B4 Waiver to increase continuity and quality of case management service delivery statewide. The Case Management provider(s) will be selected regionally through a competitive process based on their technical proposal. Provider criteria are identified in the RFP for Case Management Services and include the following:

A. Have at least two years of experience providing case management services for individuals with complex medical needs or similar services such as Rare and Expensive Case Management (REM), Model Waiver Case Management, Developmental Disabilities Service Coordination. Include with its proposal a description of the programs and services they have provided case management services.

B. Have at least two years of experience coordinating services and resources with other service providers, case managers, Home Health Agencies, local departments of social services and local health departments.

C. Have at least two years of experience and knowledge of Maryland Medical Assistance, community programs and services, and resources for adults with disabilities and low income individuals.

D. Possess written material that is accessible to case managers to include, but not be limited to: resource information on home and community programs, COMAR 10.09.55, Medicaid State Plan Services including Managed Care Organizations, Medicare, private insurance, public, private and non-profit assistance programs available to assist individuals with disabilities and limited income with housing, transportation, social services (food stamps, etc.), and centers for independent living.

E. Have at least three years of experience in providing services in a cost-efficient manner.

F. Be capable of communicating and providing written materials in alternative formats, if requested. These include material in large print, on disk, in Braille, translators, and interpreters. All informational materials shall be approved by LAH before use.

1. Be culturally sensitive in all business practices and effectively relate to the cultural/ethnic diversity of applicants, participants, their families and representatives.

G. Communicate and coordinate effectively with all programs and services with which the participant is associated.

2. Provide an accessible environment in compliance with the Americans with Disability Act (ADA).

Verification of Provider Qualifications**Entity Responsible for Verification:**

LAH Waiver Division

Frequency of Verification:

No less than annually.

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Statutory Service **Service:**Adult Day Health 

Alternate Service Title (if any):

Medical Day Care

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☐ Service is included in approved waiver. There is no change in service specifications.
- ☒ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Medical day care means medically supervised, health-related services provided in an ambulatory setting to medically handicapped adults, who, because of their degree of impairment, need health maintenance and restorative services supportive to their community living.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The amount of time a participant spends in MDC is based on AERS recommendation in POS. MDC payments can not exceed \$73.27 per day. A unit of service is no less than 4 hours a day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Day Care

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Medical Day Care****Provider Category:**

Agency

Provider Type:

Medical Day Care

Provider Qualifications**License (specify):**

Providers are required to be licensed as a Medical Day Program in accordance with Office of Health Care Quality regulations for Medical Day Centers.

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Office of Health Care Quality and the Office of Health Services

Frequency of Verification:

The Office of Health Care Quality conducts annual surveys; providers must meet all requirements prior to enrollment. The Office of Health Services conducts on-site visits of Medical Day Care Centers.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

To participate in the Program as a provider of assistive technology services under Regulation .20 of this chapter, a provider shall: Be one of the following entities: The store, vendor, organization, or company which sells or rents the equipment or system; or a Program provider of disposable medical supplies and durable medical equipment under COMAR 10.09.12; provide or arrange for any installation, servicing, training, or monitoring required for the proper operation of the device or system; and provide services in accordance with written estimated start and completion dates.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The payment rate for this service is up to \$1,000.00 per unit or \$6,246.66 per 12 month period. Cost cap includes both Environmental Accessibility Adaptations and Assistive Technology services.

Service Delivery Method *(check each that applies):*

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies):*

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Individual 

Provider Type:

Individual or Agency

Provider Qualifications**License (specify):**

To participate in the Program as a provider of assistive technology services, a provider shall: Be one of the following entities: The store, vendor, organization, or company which sells or rents the equipment or system; or A Program provider of disposable medical supplies and durable medical equipment.

The Assistive Technology providers shall provide or arrange for any installation, servicing, training, or monitoring required for the proper operation of the device or system.

Assistive Technology providers shall provide services in accordance with written estimated start and completion dates.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications**Entity Responsible for Verification:**

LAH Waiver Division

Frequency of Verification:

Provider credentials are verified upon enrollment as a provider and quarterly.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

The definition of "Unit of service" regarding consumer training means an hour of service rendered one-on-one by a qualified provider to a participant, not including the time spent by the provider. Planning, preparing, or setting up the training or following up after the training.

Consumer training includes instruction and skill building in such areas as how to recruit, select, train, direct, supervise, and fire consumer-employed attendants, as well as money management, budgeting, independent living, meal planning, and other areas specified in the participant's plan of service.

The topics covered by consumer training shall: be specified in the participant's plan of service as necessary to safely maintain the participant at home; Be targeted to the individualized needs of the participant receiving the training; and be sensitive of the educational background, culture, and general environment of the participant receiving the training. Consumer training shall include updates as necessary to maintain or improve skills, if these updates are preapproved in

the plan of service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A qualified provider may bill an all-inclusive rate not to exceed \$40.12 for each hour of covered service.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consumer Training

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications

License (*specify*):

no license required

Certificate (*specify*):

No certification required

Other Standard (*specify*):

To participate in the Program as a provider of consumer training, a provider shall: Be a self-employed trainer or an agency, that employs qualified trainers.

Providers shall demonstrated experience with the skill being taught; and be willing to meet at the participant's home to provide services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The LAH Waiver program evaluates providers prior to enrollment and on-going.

Frequency of Verification:

Initially and quarterly

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Dietitian Nutrition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Dietitian and nutritionist services shall include the provision of nutrition care plan outcomes and approaches as part of the waiver multidisciplinary team process; nutrition care planning, nutrition assessment, and dietetic instruction; and services within the scope of practice of the nutritionist's or dietitian's license, as defined by Health Occupations Article, Title 5, Annotated Code of Maryland; and Regulations under COMAR 10.56 for the Board of Dietetic Practice.

Dietitian and nutritionist services may not include services rendered on a group basis or in a classroom setting. The services shall be covered if the participant's medical condition requires the judgment, knowledge, and skills of a licensed nutritionist or licensed dietitian; targeted to the individualized needs of the participant, rather than being of general interest; sensitive to the educational background, culture, religion, eating habits, preferences, and general environment of the participant; and specified in the participant's plan of service as necessary to ensure the participant's health and safety; and prevent the participant's institutionalization or hospitalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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Service Delivery Method (check each that applies):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (check each that applies):

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Dietitian Nutrition Services

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications

License (specify):

Specific requirements for participation in the Program as a provider of dietitian and nutritionist are that a provider shall be a licensed Dietitian or nutritionist or a licensed Professional group or agency which employs an individual.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (*Scope*):

Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service cost is limited to \$6,246.66 per 12 month period.

Cost cap includes both Environmental Accessibility Adaptations and Assistive Technology service.

Service Delivery Method (*check each that applies*):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Other Service****Service Name: Environmental Accessibility Adaptation****Provider Category:**Individual **Provider Type:**

Individual or Agency

Provider Qualifications**License (specify):**

To participate in the Program as a provider of environmental accessibility adaptations, a provider shall: Be the store, vendor, or contractor, from which the adaptation is purchased; Provide or arrange for any required installation, servicing, or training; and Provide services according to a written schedule indicating an estimated start date and completion date.

If construction is involved, the provider shall also meet the following requirements: Be properly licensed by the State as a contractor or builder; Be properly bonded; Agree to obtain all necessary State and local permits; Agree to ensure that the work passes the required inspections; and Agree that all work shall be performed in accordance with State and local building codes.

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

Living At Home Waiver

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Assessment

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Environmental Assessment is the completion of an on-site environmental assessment of a home or residence where the participant lives or will live as a participant; and a form approved by the Program.

An environmental assessment may not be provided before the effective date of the participant's eligibility for waiver services.

The service may be recommended by a multidisciplinary team in the plan of service for a participant when an environmental assessment is considered necessary to ensure the health and safety of a participant with special environmental needs; and obtain additional professional advice from an occupational therapist about the physical structure of a participant's home or residence; and functional or mental limitations or disabilities of a participant as they relate to the environment.

Included in the environmental assessment, as necessary, may be an evaluation of the presence and likely progression of a disability or a chronic illness or condition in a participant; environmental factors in the facility or home; the participant's ability to perform activities of daily living; the participant's strength, range of motion, and endurance; the participant's need for assistive devices and equipment; and the participant's, family's, or service provider's knowledge of health, safety, and stress reduction factors.

Based on an inspection of the home and interviews with the participant, family, or service provider, the provider shall complete a form, to be reviewed by the case manager, which details the provider's findings and recommendations, especially relating to a participant's need for the waiver services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Environmental Assessment is capped at 395.59 per assessment.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Environmental Assessment

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications**License (specify):**

To participate in the Program as a provider of environmental assessments, a provider shall: Be a licensed occupational therapist, or an agency or professional group employing a licensed occupational therapist.

Certificate (specify):

--

Other Standard (specify):

To participate in the Program as a provider of environmental assessments a provider shall: Receive a referral from the participant's case manager, based on services preauthorized in the plan of care; and Document the provider's findings and recommendations on a form approved by the Program.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Living at Home Waiver

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Family Training as a "Unit of service" means an hour of service rendered by a qualified provider to one or more family members at the same time in the participant's home or the provider's office, regardless of the number of family members trained at one time, not including the time spent by the provider; planning, preparing, or setting up the training; or following up after the training.

"Family member" means an individual who; lives with or provides assistance to the participant; and is not paid to provide the care.

Family training includes instruction about treatment regimens and the use of equipment specified in the plan of service. The topics covered by family training shall be specified in the participant's plan of service as necessary to safely maintain the participant at home; targeted to address the individualized needs of the participant whose family member is receiving the training; and sensitive of the educational background, culture, and general environment of the family member receiving the training.

Family training shall include updates as necessary to continue to safely maintain the individual at home, provided these updates are preapproved in the plan of service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not exceed eight hours per day.

Service Delivery Method (check each that applies):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (check each that applies):

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Training

Provider Category:

Individual

Provider Type:

Individual or agency

Provider Qualifications

License (specify):

To participate in the Program as a provider of family training services, a provider shall be one of the following self-employed professionals: A licensed Registered nurse or nurse practitioner; A licensed Occupational therapist; licensed Speech pathologist or a licensed Physical therapist.

An agency which employs or contracts with a licensed professional who will render the service; and have demonstrated experience in the following: Skill being taught; and Training of personal care aides, or attendants.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver Program

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.

- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Home Delivered meals are defined as the meal shall be intended for consumption at home.

This service may not constitute the participant's full nutritional regimen of three meals per day.

Each meal shall be nutritionally adequate for the participant's age based on the Recommended Dietary Allowance (RDA) or Dietary Reference Intake (DRI), as established by the Food and Nutrition Board of the National Research Council; and meet either of the following; at least 1/3 of the RDA or DRI; or therapeutic or restrictive diet requirements ordered by the participant's physician, dietitian, or nutritionist, including any ordered nutritional supplements.

The Program's coverage under this regulation may not; result, when combined with home-delivered meals received under Title III of the Older Americans Act, in public funding for the participant's full daily nutritional regimen of three meals; or supplant payment for home-delivered meals under Title III.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

--

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Delivered Meals

Provider Category:

Individual ▼

Provider Type:

Individual or Agency

Provider Qualifications

License (specify):

Specific requirements for participation in the Program as a provider of home-delivered meals are that a provider shall:

Be approved and monitored by the Department; and Use a cooking facility or food preparation site that: Has a food service license issued by the local health department, or an appropriate license from the state in which the site is located; and Is approved for each licensing renewal based on inspections performed by State sanitarians, or by the licensing authority in the state in which the site is located.

Certificate (specify):

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Other Standard (specify):

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Verification of Provider Qualifications**Entity Responsible for Verification:**

Living at Home Waiver

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Agency Family Training

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ Service is included in approved waiver. There is no change in service specifications.
- ☐ Service is included in approved waiver. The service specifications have been modified.
- ☐ Service is not included in the approved waiver.

Service Definition (Scope):

Family training includes instruction about treatment regimens and the use of equipment specified in the plan of care. It includes updates as necessary to safely maintain the individual at home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

An hour equals one unit of service. This service may not exceed eight units of service rendered in one day.

Service Delivery Method (check each that applies):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family Training

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Non-Agency Family Training

Provider Category:

Individual **Provider Type:**

Family Training

Provider Qualifications**License (specify):**

To participate in the Program as a provider of family training services, a provider shall be one of the following self-employed professionals: A licensed Registered nurse or nurse practitioner;

A licensed Occupational therapist; licensed Speech pathologist or a licensed Physical therapist.

Certificate (specify):

None

Other Standard (specify):

None

Verification of Provider Qualifications**Entity Responsible for Verification:**

Living at Home Waiver Division

Frequency of Verification:

Initially upon enrollment and quarterly

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Agency Nursing Supervision

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

A nursing supervision "Unit of service" means an hour of service rendered one-on-one by a nurse monitor for a participant in the participant's home or another community-based setting where attendant care services are received.

Nursing supervision services include the following nursing services provided in conjunction with a visit to the participant, if specified in the participant's plan of service and rendered by a licensed registered nurse or nurse practitioner: Development of the participant's specific plan for attendant care: After consultation with the participant, family members, participant's personal physician, case manager/co-planner, and other providers, as necessary; and in conformance with the participant's: AERS assessment; AERS plan of care; and Plan of service.

Providing specific, health-related information and training to the attendant or attendants concerning topics related to the nursing care of the participant, as necessary, including: the performance of the individualized services ordered in the participant's specific plan for attendant care; and conditions or incidents that should be brought to the attention of the attendant care provider agency, the nurse monitor, personal physician, or case manager/co-planner.

Nursing Supervision provides information concerning the ongoing care or progress of each participant receiving nursing supervision services from the provider.

Nursing Supervision ensures that each attendant or prospective attendant to be supervised by the provider meets the requirements in Regulation .06A and B of this chapter;

Nursing supervision of the participant's medical condition and the care rendered by an attendant, including any delegated nursing functions performed by an attendant, in accordance with COMAR 10.27.11 and the schedule specified in §B(6) of this regulation, by reviewing during a visit the participant's plan of service and specific plan for attendant care; interactions and relationship between the participant and the attendant; attendant's performance and ability to render the required services; and participant's medical condition and need for attendant care services or for referral to other services.

Nursing supervision services provides the necessary type and frequency of nursing supervision required in accordance with COMAR 10.27.11, with the exception of COMAR 10.27.11.04C, including visits to a participant's home or other service delivery site for observation at least every; 45 days if the attendant administers medications to the participant; 3 months if the attendant assists the participant with self-administration of medications; 4 months if the attendant does not administer medications or assist the participant with medication self-administration; or at a greater frequency established by the nurse monitor due to the participant's medical condition or clinical status.

Rendering a professional evaluation, in accordance with Regulation .06A(4) and B(2) of this chapter, of a prospective consumer-employed or agency-employed attendant's ability to understand and carry out the participant's specific plan for attendant care.

Documenting an action plan to address all health and safety or medical concerns, including missed nursing supervision visits, and providing a copy of this to the case management agency within 5 business days.

The services covered under this regulation may not include nursing services other than those services described in this regulation

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

--

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
- ☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Agency Nursing Supervision

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (*specify*):

Non-agency providers of Nursing Supervision are required to hold a license as a Registered Nurse or a

Nurse Practitioner.

Certificate (*specify*):

N/A

Other Standard (*specify*):

Non-agency nurses must be willing to take responsibility for delegating nursing tasks to individuals without formal training to perform attendant care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver Division

Frequency of Verification:

Information is verified before enrollment, during quarterly query of expired credentials in the database, during desk and on-site audits.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nursing Supervision

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (*Scope*):

A nursing supervision "Unit of service" means an hour of service rendered one-on-one by a nurse monitor for a participant in the participant's home or another community-based setting where attendant care services are received.

Nursing supervision services include the following nursing services provided in conjunction with a visit to the participant, if specified in the participant's plan of service and rendered by a licensed registered nurse or nurse practitioner: Development of the participant's specific plan for attendant care: After consultation with the participant, family members, participant's personal physician, case manager/co-planner, and other providers, as necessary; and in conformance with the participant's: AERS assessment; AERS plan of care; and Plan of service.

Providing specific, health-related information and training to the attendant or attendants concerning topics related to the nursing care of the participant, as necessary, including: the performance of the individualized services ordered in the participant's specific plan for attendant care; and conditions or incidents that should be brought to the attention of the attendant care provider agency, the nurse monitor, personal physician, or case manager/co-planner.

Nursing Supervision provides information concerning the ongoing care or progress of each participant receiving nursing supervision services from the provider.

Nursing Supervision ensures that each attendant or prospective attendant to be supervised by the provider meets the requirements in Regulation .06A and B of this chapter;

Nursing supervision of the participant's medical condition and the care rendered by an attendant, including any delegated nursing functions performed by an attendant, in accordance with COMAR 10.27.11 and the schedule specified in §B(6) of this regulation, by reviewing during a visit the participant's plan of service and specific plan for attendant care; interactions and relationship between the participant and the attendant; attendant's performance and ability to render the

required services; and participant's medical condition and need for attendant care services or for referral to other services.

Nursing supervision services provides the necessary type and frequency of nursing supervision required in accordance with COMAR 10.27.11, with the exception of COMAR 10.27.11.04C, including visits to a participant's home or other service delivery site for observation at least every; 45 days if the attendant administers medications to the participant; 3 months if the attendant assists the participant with self-administration of medications; 4 months if the attendant does not administer medications or assist the participant with medication self-administration; or at a greater frequency established by the nurse monitor due to the participant's medical condition or clinical status.

Rendering a professional evaluation, in accordance with Regulation .06A(4) and B(2) of this chapter, of a prospective consumer-employed or agency-employed attendant's ability to understand and carry out the participant's specific plan for attendant care.

Documenting an action plan to address all health and safety or medical concerns, including missed nursing supervision visits, and providing a copy of this to the case management agency within 5 business days.

The services covered under this regulation may not include nursing services other than those services described in this regulation.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

One hour of service is equal to one unit. Services may not be provided in excess of eight units per day.

Service Delivery Method (*check each that applies*):

- ☐ Participant-directed as specified in Appendix E
☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual and Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Nursing Supervision

Provider Category:

Individual

Provider Type:

Individual and Agency

Provider Qualifications

License (*specify*):

To participate in the Program as a provider of nursing supervision of attendants, a provider shall be: A self-employed licensed registered nurse or nurse practitioner.

An agency or clinic which employs licensed registered nurses or nurse practitioners. The registered nurse or nurse practitioner who renders nursing supervision services shall be an individual who is:

Self-employed; or Employed by or under contract with an agency;

Meet the requirements of the Maryland Board of Nursing regarding nursing services and delegation of nursing functions; Be willing to delegate nursing tasks to unlicensed, certified individuals; and

Agree to maintain detailed, written documentation of services rendered to participants including progress

notes and service outcomes, as specified by the Department.

A provider shall ensure that a nurse monitor is available to provide the nursing supervision services.

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System-Monitoring

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (*Scope*):

A personal emergency response system is an electronic device or system which enables a participant to secure help in an emergency. There are several different kinds.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Monitoring limits are \$45.00.

Service Delivery Method (*check each that applies*):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response System-Monitoring

Provider Category:

Individual 

Provider Type:

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

To participate in the Program as a provider of personal emergency response systems, a provider shall: Be the store, vendor, organization, or company which sells, rents, installs, services, or runs the device or service; Provide or arrange for any installation, servicing, training, or monitoring required for the device or system; and Assure that any response center is: Responsible for monitoring or responding to a notification of an emergency by the system; and Adequately staffed 24 hours a day, 7 days a week by properly trained staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service 

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System-Purchase

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (*Scope*):

PERS is an electronic device or system, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended

periods of time, and who would otherwise require extensive routine supervision. PERS systems may include motion detector when necessary for the health, safety and welfare of the waiver participant.

Definition. "Unit of service" means any of the following coverages related to a device, system, or piece of equipment covered under this regulation:

(1) Purchase and installation;

A personal emergency response system is an electronic device or system which enables a participant to secure help in an emergency and may include but not be limited to:

(1) A device connected to the participant's telephone or other device and programmed to signal, upon activation of a help button, a response center with properly trained staff on duty 24 hours a day, 7 days a week;

(2) A portable help button to allow for the participant's mobility; and

(3) A motion detector when necessary for the participant's health, safety, and welfare.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Unit may not exceed amount specified annually in provider rate transmittal. In 2009, this amount was \$1,362.90 for system with motion detector or \$45.00 per month for the monitor only system.

Service Delivery Method (*check each that applies*):

☐ Participant-directed as specified in Appendix E

☒ Provider managed

Specify whether the service may be provided by (*check each that applies*):

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual or Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Personal Emergency Response System-Purchase

Provider Category:

Individual

Provider Type:

Individual or Agency

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

To participate in the Program as a provider of personal emergency response systems, a provider shall: Be the store, vendor, organization, or company which sells, rents, installs, services, or runs the device or service; Provide or arrange for any installation, servicing, training, or monitoring required for the device or system; and Assure that any response center is: Responsible for monitoring or responding to a notification of an emergency by the system; and Adequately staffed 24 hours a day, 7 days a week by properly trained staff.

Verification of Provider Qualifications

Entity Responsible for Verification:

Living at Home Waiver

Frequency of Verification:

Upon enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transition Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- ☒ **Service is included in approved waiver. There is no change in service specifications.**
- ☐ **Service is included in approved waiver. The service specifications have been modified.**
- ☐ **Service is not included in the approved waiver.**

Service Definition (Scope):

Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institution to a private residence where the individual is directly responsible for his or her living expenses. The goal is to enable the individual to set up a basic household when that individual lacks the resources to bear the expense and other resources are not available. Allowable expenses that do not constitute room and board, may include the following:

Security deposits to obtain a lease on an apartment or home

Essential furnishings and moving expenses

Set-up fees for access or deposits for utility services

Services necessary for the individuals health and safety such as pest eradication

Necessary home environmental adaptations

Transition Services must be reasonable and necessary as determined through the plan of care process and may not include monthly rental or mortgage expenses, food, regular utility costs, food and or items used for solely recreational purposes. Transition Services must be identified in the plan of care and rendered by a qualified provider.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This is a one time service available to participants enrolling from nursing facilities. The cost cap is \$3,000. payable to the provider after transition has taken place.

Service Delivery Method (check each that applies):

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by (check each that applies):

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service
Service Name: Transition Services

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications**License (specify):**

There are no licensing requirements for Transition Services providers.

Certificate (specify):

There are no certificates required to be a Transition Services provider.

Other Standard (specify):

To participate in the Program as a provider of transition services a provider shall have experience in: Assisting individuals to transition from a nursing facility to a community-based residence; and Arranging and coordinating the services necessary to facilitate the transition. Currently, the contracted case management agency is required to enroll as a provider to perform this service.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Living at Home Waiver

Frequency of Verification:

Annually

Appendix C: Participant Services**C-1: Summary of Services Covered (2 of 2)**

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3. Do not complete item C-1-c.**
- ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). Complete item C-1-c.**
- ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). Complete item C-1-c.**
- ☐ **As an administrative activity. Complete item C-1-c.**

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

The Living at Home Waiver will begin to offer case management as a waiver service on November 1, 2009, when the existing contract for administrative case management services expires. The Department is applying for a 1915 (b)(4) waiver in order to limit providers of this service. Administrative case management services will continue to be available to pending applicants. The service provider will be selected through a solicitation and the Department anticipates awarding one contractor per region or one contractor statewide.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

This requirement may be waived for participants using the non-agency or consumer model of attendant care, who make a written request to the Department. Requests are subject to approval by the Department.

- b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ☒ **No. The State does not conduct abuse registry screening.**
- ☐ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

- c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- ☒ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ☐ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☒ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☐ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☒ **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

The waiver makes payment when family members enroll to provide non-agency attendant care services. Case managers do monthly contacts and quarterly visits to ensure coordination and delivery of services.

- ☒ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- ☐ **Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Living at Home Waiver program accepts provider applications on an ongoing basis. Requests for provider applications may be made via phone, fax or email, and the "Provider Application Request Form" may be down loaded from the Department of Health and Mental Hygiene website and faxed to the Living at Home Waiver program. The Living at Home Waiver Division has a staff person assigned to review and certify provider applications.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

i. Sub-Assurances:

- a. *Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

PERCENT OF PROVIDERS WHO INITIALLY MEET LICENSURE AND/OR CERTIFICATION STANDARDS; Numerator: Total # of providers requiring licensure and/or certification who enroll as waiver providers (meet requirement); Denominator: Total # of providers requiring licensure and/or certification who submitted a provider application.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100 % Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>

	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

PERCENT OF PROVIDERS WHO MEET ONGOING LICENSURE AND/OR CERTIFICATION STANDARDS; Numerator: The Number of providers who qualify to maintain enrollment after post-enrollment review by LAH staff of credentials. Denominator: the Number of providers reviewed for qualifications.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Internal Access Provider Database

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

PERCENT OF PROVIDERS WHO MEET LICENSURE AND/OR CERTIFICATION STANDARD DURING AUDIT PROCESS. Numerator: Total number of providers, who require licensure and/or certification to perform services, meeting standards during audit; Denominator: Total number of providers audited who require licensure and/or certification to perform services.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. **Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Attendant care providers are required to submit Provider Service Reports with time sheets for payment to be rendered for services delivered. Numerator: Number of attendant care claims paid which do not have required Provider Service Reports and timesheets attached. Denominator: Number of attendant care claims paid.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Transition Services claims are paid in accordance with waiver requirements. Numerator: Number of transition claims that are paid. **Denominator:** Number of transition service claims received at LAH.

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Livig at Home Waiver will be developing updated provider trainings over the next year.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Provider problems are identified through reportable events, complaints, provider service reports, provider claims and other sources. When program issues are identified, the LAH Waiver Division will refer the problem to the individual assigned to that area (see title and function list below). Generally, the staff person will immediately identify the impact of an issue and refer to staff for resolution as follows:

Quality of Care Issues to include reportable events, critical incidents, complaints, neglect, abuse, service delivery interruption-Quality Assurance Specialist, Medical Program Supervisor and Division Chief

Provider Enrollment, Credentialing, Capacity-Provider Specialist and Medical Care Program Specialist

Claims Payment, Fiscal Intermediary Issues-Agency Budget Specialist, Medical Care Program Associates

Tracking System Issues-Quality Assurance Specialist

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

- a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ☒ **Not applicable** - The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ☐ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Plan of Service (POS)

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker.***Specify qualifications:*☐ **Other***Specify the individuals and their qualifications:***Appendix D: Participant-Centered Planning and Service Delivery**

D-1: Service Plan Development (2 of 8)**b. Service Plan Development Safeguards. *Select one:***

- ☒ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ☐ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)**c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) Case managers, participants, their friends and family members are the central members of the team developing the POS, and are provided with written and/or oral information about LAH services and the process of developing a POS tailored for the individual. Participants have the support of a service coordinator to assist them by facilitating the planning meeting and assisting in the creation of the POS.

(b) Applicants and participants receive information from their case manager about their right to invite family members, friends, professionals, and anyone else they desire to be part of team meetings and/or their circle of support, and are encouraged to involve important people in their lives in the planning process.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when

the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- (a) Several entities are involved in the development of the POS with the applicant or participant, including the case management agency and the local health department AERS evaluators. The process is initiated by the LAH case manager (CM) after the applicant has received an application for enrollment from DHMH.
- (b) The AERS assessment is conducted and recommendations are shared with the CM. The CM has a face-to-face meeting with the participant to explore the participant's needs, preferences and goals. If a participant is transferring from a nursing facility, discharge information will be available about the participant's health status and follow-up issues. The CM ensures that the applicant or participant has a current, signed release of information form allowing them to contact relevant parties on their behalf.
- (c) In the initial meeting between the CM and the participant, the CM provides the participant with detailed information about all LAH waiver services.
- (d) The plan of service development process ensures the participant's needs and preferences are addressed because the participant is involved in the entire plan of care development. The waiver POS lists the type, amount, frequency, cost, duration, and provider for all waiver, State Plan, community-based and informal services. The participant is asked to sign the POS; therefore, any participant concerns would have to be addressed before the plan could be considered final.
- (e) The CM is responsible for the coordination of waiver and other services to ensure the participants needs and interests are addressed. The participant may opt to participate in the coordination activities.
- (f) The interactive nature of planning for consumer-directed services effects the assignment of responsibilities as the POS is developed. As the participant makes known the extent of self-directed services they are interested in, the POS will naturally reflect the shared responsibilities of the participant and the CM. The participant and CM will communicate a minimum of once a month, and monitoring occurs as they discuss the participant's services, needs and preferences. Additionally, the CM and participant will have a face-to-face meeting every three months which is also part of the monitoring process.
- (g) The POS must be updated at least annually but more frequently if the participant's status or needs change. The monthly communication and every three month face-to-face meeting enable changes to be implemented in the POS in a timely manner.

The CM works with the participant to develop a waiver POS, coordinate the delivery of waiver services in accordance with the POS, and to update the POS as necessary. Upon receiving the AERS evaluation and approved LOC for an applicant or participant, the CM conducts a face-to-face meeting with the applicant or participant to begin to develop their POS. The waiver POS lists the type, amount, frequency, cost, duration, and provider for all waiver, State Plan, community-based and informal services. If authorized by the participant, the CM may also contact the individual's authorized representatives, family members, informal supports, NF staff, to determine needs and available supports for the POS. Additionally, the case management agency employs a nurse consultant specifically for the LAH waiver to answer questions or concerns of a clinical nature.

The CM provides each applicant and participant with the current DHMH LAH provider listing in order to facilitate the participant's choice of providers. The CM is responsible for on-going monitoring of the POS to ensure that it is cost neutral and continues to meet the participant's needs. The POS may be updated any time the participant's needs change. On an annual basis, the CM coordinates the annual reassessment of participant eligibility which includes updating the POS. AERS staff performs an evaluation as part of the annual reassessment and recommends services to address the participant's needs.

The CM tracks the eligibility process by using a tracking form which documents current information about waiver applicants and participants. The data collected on the tracking form is used to track time frames for eligibility determination requirements, including the development and implementation of the initial and annual POS.

The CM's tracking form is an internal database within the CM contractor. In addition to using their tracking form, the CMs are required to use the LAH web-based tracking system.

The Living at Home Waiver Tracking System is designed to electronically store clients' most up-to-date waiver information, including diagnosis, plan of service information, case management notes, and referral creation and approval information. The Living at Home Waiver Tracking System provide a centralized task oriented web based system to track applicants and participants that will present stakeholders with real time access to information. Streamline enrollment and redetermination process. Standardize forms and processes. The Living at Home Waiver Tracking System will function as a management tool increasing efficiency and accountability. Users will have the capability to view client history identifying key dates of the enrollment process and documentation. Examples of documentation include eligibility letters, narrations, ATPs, LOCs, POS just to name a few. Documents can be submitted with the click of a button, decreasing the need to fax and mail documents. Due to the fact the system is task oriented all users are guided through the same eligibility steps using the same forms. The Living at Home Tracking System has the capability to provide various reports, alerts users of cases needing action or determinations made.

LAH staff reviews 100% of all POS and POS modifications prior to approval. LAH staff ensure that the applicant or participant (or representative) sign the POS indicating their agreement with the services; that services are consistent with the AERS recommendations for health and safety; that there is documentation to explain situations where a POS deviates from the AERS recommendations; that all informal care provisions are documented; that the POS cost, inclusive of State Plan and waiver services, is within the current cost neutrality amount. DHMH will be implementing a new policy to allow individuals transitioning from nursing facilities to the community to use an increased cost neutrality cap for their initial year of waiver services. LAH staff is currently evaluating the feasibility of CM approval of POS under certain circumstances.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

As part of the participant's POS, the individual's health and safety needs are assessed by the service coordinator. Risk mitigation strategies, including back-up plans that are based on the unique needs of the individual, and must ensure health and safety while affording an individual the dignity of risk. Individualized risk mitigation strategies are incorporated directly into the POS and are done in a manner sensitive to the individual's preferences. The plan of service will not be approved by LAH staff unless the individual's POS contains a reasonably designed back-up system for emergencies, including situations in which a scheduled employee does not show up to provide services. Risk mitigation strategies may include individual, family, and staff training, assistive technology, back-up staffing, etc.

In addition, all LAH agency attendant care service providers must have a system for providing emergency back-up services and supports in the event that scheduled employees are absent.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The case manager assists the individual in selecting his or her community provider agency. Both the individual and case manager can access a current listing of licensed providers offering services which is maintained by LAH provider specialist. Participants are encouraged to consider multiple providers and meet and interview staff prior to selection in order to make an informed choice. Once the participant has chosen his or her provider agency, the case manager will place the chosen provider into the participant's POS for a predetermined frequency of visits.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

LAH staff reviews 100% of all POS and POS modifications prior to approval. LAH staff ensure that the applicant or participant (or representative) sign the POS indicating their agreement with the services; that services are consistent with the AERS recommendations for health and safety; that there is documentation to explain situations where a POS deviates from the AERS recommendations; that all informal care provisions are documented; that the POS cost, inclusive of State Plan and waiver services, is within the current cost neutrality amount. LAH staff is currently evaluating the feasibility of CM approval of POS under certain circumstances.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary
- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☒ Medicaid agency
- ☐ Operating agency
- ☒ Case manager
- ☐ Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The case manager is responsible for monitoring the implementation of the service plan and participant health and welfare during monthly contacts and quarterly face-to-face visits. Case managers also monitor service implementation by contacting service providers when a participant or authorized representative reports problems with service delivery.

(b) One tool used for monitoring is the Provider Services Report (PSR) that is completed by the independent or agency nurse after each visit to the participant. The RN must submit a copy of the PSR to the case manager after each visit. This provides up-to-date clinical and functional information that the CM can use to monitor the effectiveness of the POS, particularly with regard to the participant's health and safety.

(c) Case managers maintain monthly contact with participants to ensure that services are being received and to determine if needs are met. Case managers make face-to-face contact with participants no less than quarterly. In addition, case managers are required to be available at the participant's request. Attendant care providers are required to submit PSR forms with each timesheet.

b. Monitoring Safeguards. Select one:

- ☐ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- ☒ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

The case management agency is responsible for the administration of transition services to applicants moving from nursing facilities into the community. The contractor does not receive an administrative fee for performing this service; it is a requirement of the case management contract. The contractor does not have plan of service approval authority.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of Plans of Services reviewed that meet all participant needs either through waiver services or another means. Numerator: Number of Plans of services reviewed that meet all participants needs either through waiver services or another resource.

Denominator: Number of POS reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Plans of Services reviewed via tracking system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Percentage of Plans of Service (POS) reviewed during annual Quality of Care Review Team (QCRT) survey meeting all participant needs (health and safety, personal goals, other needs). Numerator: Number of POS reviewed during the annual QCRT review that meet participant needs, as defined above, through waiver or non-waiver services. Denominator: Number of POS reviewed during the annual QCRT review.

Data Source (Select one):**Other**

If 'Other' is selected, specify:

Review consists of interviews with participants, reviews of records in tracking system, review of records at the case management agency.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
--	---	--

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 3
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of Plans of Service Reviewed by the LAH Waiver Program. Numerator:
Number of POS reviewed by LAH. Denominator: Number of POS received by LAH.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the

waiver participant's needs.

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Case managers implement changes to waiver plans of service based on a participant's request for a change in provider, frequency of service delivery or type of service.

Numerator: # of changes to plans of service requested by participant Denominator: # of plan of service change requests approved

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100 % Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = 5
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Percentage of attendant care and nurse monitor services received. Numerator: Number of units of attendant care and nurse monitor services for which claims are paid.

Denominator: Number of units of attendant care and nurse monitor services included in participant plans of service.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- e. **Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.**

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

LAH investigates all complaints about issues with plan of services development. The LAH Quality Specialist and Medical Care Program Supervisor provide education to the provider and then request a Corrective and Preventative Action Plan if the problem is not resolved.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually <input checked="" type="checkbox"/> Continuously and Ongoing <input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

- ☐ **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ☒ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

(a) Participants in the LAH waiver are given the opportunity to direct providers of agency and non-agency attendant care services. Participants who are cognitively capable may opt to self-direct their non-agency independent attendant care providers, in lieu of using monitoring, to assist the participant with routine care and self-administration of medication. The Board of Nursing regulation (COMAR 10.07.11.01D) supports this policy.

(b) LAH case managers engage applicants and participants about informed decision making regarding provider choice, model of attendant care, and the availability of self-directed attendant care services. The plan of service reflects all services needed for healthy and safe community living, including areas where the participant will be directing care.

(c) The case manager shares information about attendant care service models (agency and non-agency) and a self-delegation materials in a booklet called "Attendant Care and You." This booklet describes the role of managing providers, interviewing techniques and differentiates agency and consumer model care. These documents will assist the participant in making an informed decision regarding the direction of his/her care. If the participant is interested, the participant and the case manager (if requested) will identify the tasks that will be self-delegated. The participant and the case manager (if requested) will discuss and develop a job description and back-up plan for the attendant(s) as well as discuss and develop a plan for hiring, screening, interviewing, and training attendant(s).

Once a potential attendant has been identified, the participant will direct him/her to the LAH division to complete the provider enrollment process if necessary. If the participant and case manager agree that they are ready to move forward, a Self-Delegation Agreement will be provided to the participant for signature. The Agreement will state that the participant will be responsible for the direction and oversight of the attendant(s) and that the POS supports the participant's health and safety while receiving LAH waiver services in the community. The Agreement should only be signed when the participant is ready for total self-delegation and will include the time frame for review of the agreement, but minimally, the participant and the case manager will review it on an annual basis at redetermination. The details of the independent delegation agreement will be indicated on the waiver participants POS and attendant care service tasks are to be noted on the Caregiver Service Plan. The Self-Delegation agreement, POS and Caregiver Service Plan can be modified at any time. If the case manager determines that the participant's health is in jeopardy, a meeting will be held with the participant, case manager, nurse consultant and provider to discuss concerns and options. Strategies to address concerns will be developed such as consumer training, education provided by a nurse supervisor, follow-up training by the nurse supervisor, temporary nurse supervision and/or identification of a new attendant care provider. If the strategies are determined not to meet the participant's health and safety needs, the case manager will inform the participant that the Living at Home Waiver Division will be notified. Once notified, the LAH Waiver Division will review the information provided by the case manager and, if necessary initiate documents to reduce or discontinue self delegation of attendant care service. The participant may appeal any decision regarding his/her ability to self-delegate.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

- b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*
- ☒ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
 - ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
 - ☐ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.
- c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☐ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☐ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☐ The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☒ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

Waiver participants must be cognitively capable or have an authorized representative willing to assume employer responsibilities in order to use the non-agency or consumer model of attendant care services. Participants who choose this option for attendant care services are responsible for interviewing, hiring and terminating employees. The Office of Health Services contracts with a Fiscal Intermediary that acts as a payroll agent for these individuals. The Fiscal Intermediary is responsible for ensuring each participant/employer obtains an Employer Identification Number from the IRS, obtaining documentation from providers that supports their legal status to work in the United States, for making bi-weekly payroll payments to provider, for withholding all mandatory State and federal taxes, obtaining Workers' Compensation policies for participant/employers and processing unemployment insurance claims filed by providers.

Participant employers may choose to waive certain qualifications that are normally required in order to provide attendant care services under the LAH Waiver Program. These criteria include the age requirement of being 18 years or older, holding a certification in CPR and First Aid and completing a criminal background investigation. Participant employers also may waive the Nurse Monitor visit in advance of the attendant working for 30 days. Under a separate option, participants may elect to self-delegate Nursing Supervision of attendants ongoing.

This latter option requires a more intensive approval process by the LAH Waiver Division. This option differs from the use of the non-agency or consumer model of attendant care because the participant's authorized representative may not serve in this capacity on behalf of the participant.

The cognitively capable participant makes this request to their case manager; the nurse consultant and any other members of the individual's team who participate in the approval process. Participants must demonstrate their ability to complete paperwork that is normally required of the Nurse Monitor; they must show the ability to train attendants. Once approved, participants may discontinue performing this function and resume using a provider to function as a Nurse Monitor at any time. In addition, the LAH Waiver may rescind approval if the participant's needs change and they are no longer able to function in this capacity as part of a safe and healthy plan for community living.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Non-agency model of attendant care

Case manager

The case manager provides information about attendant care options upon completing their initial Plan of Service and no less than annually during the re-evaluation process. Participants may switch from one model of attendant care to another at any time or choose to use a combination of attendants. Case managers also provide each participant with information about the option to Self-Delegate Nurse Monitoring of their attendants. Participants receive this information no less than annually from their case manager. Potential liabilities are that the delegated care and services are not being monitored by a licensed professional with clinical skills. The benefits are that the individual is able to make independent decisions about the care and services provided (self-direction) and is responsible for those decisions.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

- f. Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ The State does not provide for the direction of waiver services by a representative.
- ☒ The State provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Applicants and participants may designate an "authorized representative" to assist with the initial or annual Medicaid eligibility process, including plan of services development and directing service delivery. In addition, some waiver participants have Guardians of Person, Guardians of Property, Powers of Attorney or surrogates under the Maryland Healthcare Decisions Act of 1993.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
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Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

☒ **Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☐ **Governmental entities**

☒ **Private entities**

☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

☐ **FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:

☒ **FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Fiscal Intermediary (FI) Services Contractor

Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants; in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers' compensation. The contract is monitored by the Agency Budget Specialist in the Living at Home Waiver Division.

Through the DHMH procurement process this vendor won the bid for the FI contract. This contract was a three year contract with two one year options. Additionally, a contract extension was requested and granted. This contract ends December 2009.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The contractor is paid when invoices are submitted to the Living at Home Division staff. For any participant not using the the agency model the contractor receives a per person per month flat rate.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assists participant in verifying support worker citizenship status
- ☒ Collects and processes timesheets of support workers
- ☒ Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- ☐ Other

Specify:

Supports furnished when the participant exercises budget authority:

- ☐ Maintains a separate account for each participant's participant-directed budget
- ☐ Tracks and reports participant funds, disbursements and the balance of participant funds
- ☐ Processes and pays invoices for goods and services approved in the service plan
- ☐ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other services and supports

Specify:

Additional functions/activities:

- ☐ Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☐ Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ☐ Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly. In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant

direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Case managers provide information and education about self-delegating opportunities to program participants when they enroll in LAH and again during the redetermination process. Participants receive written materials about self-delegation from their case managers. These documents explain their role and or liability in self-delegating and assists the participant in making an informed decision regarding the direction of his/her care. After providing an opportunity for the participant to review this information, the case manager will revisit self-delegation.

Participants may choose to self-delegate or opt to work toward this goal with their Nurse Monitor provider and case manager's assistance. The participant and their case manager sign an agreement to confirm participation. The agreement states that the participant will be responsible for the direction and oversight of the attendant(s) and that the POS supports the participant's health and safety while receiving LAH waiver services in the community. The agreement should only be signed when the participant is ready for total self-delegation and will include the time frame for review of the agreement, but minimally, the participant and the case manager will review it on annual basis at redetermination.

In addition, the participant plan of service reflects all services provided and when self-delegation is being used. The Self-Delegation agreement, POS and Caregiver Service Plan can be modified at any time. If the participant decides they would like to resume Nurse Monitor services, they may contact their case manager to request a change in their plan of service. If the case manager determines that the participant's health is in jeopardy, they are required to meet with the participant, any advocate or authorized representative, the nurse consultant and provider to discuss concerns and options.

- ☒ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Consumer Training	<input type="checkbox"/>
Personal Emergency Response System-Monitoring	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Dietitian Nutrition Services	<input type="checkbox"/>
Initial and Ongoing Case Management Services	<input checked="" type="checkbox"/>
Medical Day Care	<input type="checkbox"/>
Nursing Supervision	<input type="checkbox"/>
Environmental Accessibility Adaptation	<input type="checkbox"/>
Non-Agency Family Training	<input type="checkbox"/>
Non-Agency Nursing Supervision	<input type="checkbox"/>
Family Training	<input type="checkbox"/>
Attendant Care	<input type="checkbox"/>
Environmental Assessment	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Personal Emergency Response System-Purchase	<input type="checkbox"/>

Transition Services	
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- ☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

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Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (*select one*).

- ☒ **No. Arrangements have not been made for independent advocacy.**
- ☐ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

--

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

Participants who discontinue participating in non-agency attendant care or self-delegation of attendant care receive assistance from their case manager to choose agency based services for attendant care and nurse monitoring. These services are implemented so there are no gaps in delivery of services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If the case manager determines that the participant's health is in jeopardy, they are required to meet with the participant, any advocate or authorized representative, the nurse consultant and provider to discuss concerns and options for meeting needs. In situations where the needs are unable to be met through participant directed services, the participant receives formal notice from the LAH Waiver and is given appeal rights. Alternate services are implemented and effective when the participant directed services end so there are no gaps in service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	191	
Year 2	212	
Year 3	236	
Year 4 (renewal only)	262	
Year 5 (renewal only)	291	

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
- ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
- ☒ **Refer staff to agency for hiring (co-employer)**
- ☒ **Select staff from worker registry**
- ☐ **Hire staff common law employer**
- ☒ **Verify staff qualifications**
- ☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Cost are not currently compensated

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- ☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- ☐ **Determine staff wages and benefits subject to State limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☐ **Discharge staff (common law employer)**
- ☐ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

- b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☐ **Reallocate funds among services included in the budget**
- ☐ **Determine the amount paid for services within the State's established limits**
- ☐ **Substitute service providers**
- ☐ **Schedule the provision of services**
- ☐ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☐ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☐ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☐ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- ii. **Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- ☐ Modifications to the participant directed budget must be preceded by a change in the service plan.
- ☐ The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Appendix F: Participant Rights**Appendix F-1: Opportunity to Request a Fair Hearing**

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Medicaid provides broad Fair Hearing Rights to individuals who are denied choice of HCBS waiver services as an alternative to institutional care, denied providers of their choice, and whose services are denied, suspended, reduced or terminated. Specifically, COMAR 10.01.04 which governs Fair Hearings stipulates that the opportunity for Fair Hearing will be granted to individuals who are aggrieved by any Department or delegate agency policy, action or inaction which adversely affects the receipt, quality or conditions of medical assistance. This includes adverse action in the case of Level of Care determination; HCBS versus institutional care; choice of provider; choice of services based on substantiated need; and the denial, reduction, suspension, or termination of services. Each waiver participant (and/or his/her family or guardian as appropriate) receives a copy of the notice of fair hearing in the initial waiver application upon enrollment.

Process for Giving Notice to Applicants/Participants

If an applicant or enrolled participant is denied waiver eligibility-medical, technical or financial criteria – he/she and any representative that has been identified by the individual are sent a letter that contains the reason for the denial and a Fair Hearing notice. The Medicaid waiver eligibility unit sends all eligibility denial letters. Denial letters are copied to CMA who will maintain this documentation as part of the participant's waiver record.

If an individual requires assistance in pursuing a fair hearing, their Case Manager at the CMA will assist. Per COMAR 10.22.09.04, a key function of the resource coordinator is to "advocate for the individual to assure that the individual's rights are protected".

Appendix F: Participant-Rights**Appendix F-2: Additional Dispute Resolution Process**

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

☒ **No. This Appendix does not apply**

☐ **Yes. The State operates an additional dispute resolution process**

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant

elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DHMH

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The grievance/complaint system ensures the identification of and the appropriate and timely resolution of administrative service and quality of care complaints related to waiver participants. A complaint is defined as any communication, oral or written from a participant, participants representative, provider, or other interested party to any employee of the Department of Health and Mental Hygiene (DHMH) or the contracted Case Management Agency (CMA) expressing dissatisfaction with any aspect of DHMH, CMA, or providers operations, activities, or behavior, regardless of whether any remedial action is requested. Administrative, service related and quality of care complaints are reviewed. Quality of care complaints include, but are not limited to: concerns about perceived practitioners or provider's qualifications or competence, adverse experiences, poor outcomes, inadequate care or perceived harm, provider negligence with regards to policy and procedures, medical record documentation and confidentiality issues as well as accessibility and/or availability, which impact care.

The process used for resolving grievances/complaints begins with the Quality Assurance Specialist for the Living At Home Waiver (LAHW) at DHMH, CMA representative, provider or other interested party documenting the pertinent information and the nature of the complaint on the Reportable Events form. The Quality Assurance Specialist for the Living At Home Waiver addresses the issue according to the time frames outlined below.

The Quality Assurance Specialist completes the initial investigation and the in conjunction with CMA representative, the participant, family and other related parties, performs all necessary follow up, summarizes the finding, and determines and implements the appropriate corrective action. The Quality Assurance Specialist and the CMA maintain logs on the grievance/complaint actions reported to identify trends and patterns.

Timeframes for complaint resolution are as follows: 24 hours: emergency medically related complaints, 5 days: non-emergency medically related complaints and 30: administrative service delivery complaints. Participants always have the choice to terminate the use of a particular provider at any time and may also at any time request a Medicaid Fair Hearing in any situation that gives rise to appeal rights.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- ☒ **Yes. The State operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through*

e)

No. This Appendix does not apply (*do not complete Items b through e*)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Incidents are defined as events or situations that pose an immediate and/or serious risk to the physical or mental health, safety, or well being of a waiver participant. It may also involve the misappropriation of a waiver participant's property or a violation of the participant's rights. Incidents that are alleged to have occurred as well as the results of internal investigations are to be reported using the Reportable Events Form.

Incidents may include an allegation of, or actual occurrence of one or more of the following: Abandonment, Abuse: physical, sexual, verbal, or emotional, Accidents or injuries requiring treatment beyond first aid or patterns of accidents or injuries that potentially indicate a problem. Death: anticipated or unanticipated, Emergency Room visit, Exploitation: theft, financial, and destruction of property, Hospitalizations: anticipated or unanticipated, and an in-patient psychiatric admission, Missing Person, Neglect: nutritional, self, medical, or environmental, Treatment Error, Rights Violation, Use of restraints, including physical, chemical, and seclusion.

All entities associated with Home and Community Based Services Waivers and supports, including The Division of Waiver Programs (DWP), Administering State Agencies(ASA), Case Manager(CM), and waiver providers; personal/attendant care agencies, self-employed providers, and environmental accessible adaptations providers are required to report real or alleged Reportable Events. All Reportable Events shall be reported in full on the Reportable Event Form.

In instances of alleged or actual abuse, neglect, or exploitation, the person reporting the event must file a report immediately with Adult Protective Service (APS) office within 24 hours. For LAH participants, law enforcement and the Department of Health and Mental Hygiene must also be contacted.

The CM shall complete and forward the Reportable Events to the ASA via email or fax within 7 calendar days of knowledge of the event.

The ASA shall log all events into the Reportable Event database and will also do off-site or on-site reviews based on the nature of the incident or occurrence. The review, follow-up, and action plan shall be completed within 30 calendar days.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Case Manager currently explains the Reportable Event policy to the participants and providers involved in their care. It has been brought to the attention of the Living at Home Waiver that more training and re-education is necessary due to some inconsistencies with the RE submissions. Living At Home Waiver Division is currently in the process of developing new ways to make the RE process more user friendly with participants, providers and Case Managers. The Quality Waiver Council is in the process of reassessing the reportable events policy and procedure.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The Administering State Agency (ASA) shall log all events into the Reportable Event (RE) database. The review, follow up, and action plan shall be completed within 30 calendar days. The ASA reviews the RE's and all supporting documents to determine whether further review is needed. If further review is needed, the ASA shall follow up with the appropriate parties; determine and implement appropriate action involving the participant, waiver provider, such as, requesting a corrective action plan; and summarizing the findings. The summary information is documented on the ASA RE review Form. For RE's that require ASA review, the ASA shall send a RE status letter to the participant, their authorized representative or family member, and/or provider within 7 calendar days of completion of the review. ASA will also send a copy to the Case Manager (CM). If a RE requires an adverse action (e.g., denial or reduction of services), the ASA will ensure that the provider or participant is provided with their right to appeal. The ASA will make recommendations to DWP for review, regarding the need for Medicaid sanctions against providers.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Administering State Agency (ASA) will compile Monthly Summary Reports of all events. The ASA will compile and submit to The Division of Waiver Program (DWP) summary reports based on an agreed format and data elements including recommendations for systemic changes to improve waiver quality on a quarterly basis. The ASA and DWP will review the quarterly reports in the Waiver Quality Council meetings to make specific recommendations for program, policy, or procedure changes and determine the need and provide for technical assistance or training.

The Division of Waiver Program (DWP) shall review ASA quarterly reports from each waiver program. The DWP will compile a consolidated report based on ASA reports for the Waiver Quality Council. This report will review statewide RE trends, identify potential barriers, and make recommendations for improvement. The DWP will prepare an annual report containing analysis of the data that will review statewide trends, identify potential barriers, and make recommendations for improvement. DWP will provide this report to CMS, DHMH, the ASAs, and other stakeholders.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

- a. Use of Restraints or Seclusion.** *(Select one):*

- ☒ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

Provider agencies that are enrolled as Living at Home Waiver providers are monitored by the Office of Health Care Quality when they are Residential Services Agencies and Home Health Providers.

Adult Protective Services would address/investigate reported incidents of abuse including restraint misuse or seclusion issues (abuse).

Case managers do monthly telephone contacts and quarterly face to face visits to ensure coordination and delivery of appropriate services. Case managers are trained on how detecting with instances of abuse including unauthorized restraint use and inappropriate seclusion methods.

- ☐ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

- b. Use of Restrictive Interventions.** *(Select one):*

☒ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The Department of Health and Mental Hygiene, specifically, the Living at Home Waiver Division, is responsible to ensure that participants are receiving appropriate care and services which includes detecting the unauthorized use of restrictive devices. LAH staff approve all participant plans of services. The contracted case management agency is responsible for monthly participant contacts and quarterly home visits. Both entities are responsible for addressing reportable events/incidents which could involve unauthorized use of restrictive interventions. Participants, family members, providers are to report unusual incidents, abuse, neglect, etc. The policy and procedure specifies that Adult Protective Services and law enforcement should be notified for certain events/occurrences. The Quality Waiver Council will be responsible for the analysis of aggregate data on reportable events/occurrences across the various waivers including LAH.

☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☒ **No. This Appendix is not applicable** (do not complete the remaining items)
- ☐ **Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

- i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.**
(complete the remaining items)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

PERCENT OF REPORTABLE EVENTS INVOLVING ABUSE, NEGLECT AND/OR EXPLOITATION; Numerator: Total # of reported and investigated Reportable Events involving abuse, neglect and/or exploitation; Denominator: Total# of total incidents reported.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

In instances of alleged or actual abuse, neglect or exploitation, the person reporting the event must file a report immediately with Adult Protective Services within 24 hours. For LAH participants, the law enforcement and DHMH must also be contacted. Reportable events(RE) involving abuse, neglect and misappropriation of property/funds are sent to LAH from case managers and providers on a continuous basis. Participants and family members report such incidences to case managers. Case managers investigate all incidents to completion. The LAH Quality Assurance Specialist reviews all of the incidences listed above. On-site visits may be conducted by LAH staff or the Quality Care Review Team. All reportable event information is entered into a database to analyze and compile RE information and generate specific reports to track and trend. LAH staff determine if findings require a corrective action plan or referral to Office of Health Care Quality, Licensing Boards, other agencies,etc. This information is shared on a quarterly basis with the Waiver Quality Council.

- ii. **Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☐ No

☒ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

In instances of alleged or actual abuse, neglect, or exploitation, the person reporting the event must file a report immediately with Adult Protective Service (APS) office within 24 hours. For LAH participants, the law enforcement and the DHMH must also be contacted. Issues involving threats to participant health and safety, including abuse, and neglect will be immediately researched by LAH program staff (Participant Specialist & Quality Assurance Specialist). They must notify the Division Chief and the Deputy Director of Long term care and waiver services of the incident within 24 hours.

The CM/SC shall complete and forward the Reportable Events to the ASA via email or fax within 7 calendar days of knowledge of the event.

The ASA shall log all events into the Reportable Event database. The review, follow-up, and action plan shall be completed within 30 calendar days.

The reportable quarterly reports are reviewed in the Quality Waiver Council to make specific recommendations for program, policy, procedure, and system changes. In addition, the Council will determine the need for technical assistance, training or other remedies/actions. Technical assistance and training will be provided by the appropriate DHMH staff.

The Division of Waiver Program (DWP) shall review ASA quarterly reports from each waiver program. The DWP will compile a consolidated report based on ASA reports for the Waiver Quality Council. This report will review statewide RE trends, identify potential barriers, and make recommendations for improvement. The DWP will prepare an annual report containing analysis of the data that will review statewide trends, identify potential barriers, and make recommendations for improvement. DWP will provide this report to CMS, DHMH, the ASAs, and other stakeholders.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The analysis of discovery data and remediation information is conducted on an on-going basis due to the waiver design feature of varied types of regular reporting and communications among waiver partners and stakeholders, as well as the forums of the LAH Waiver Advisory Committee and the Waiver Quality Council. LAH is the lead entity responsible for tracking, trending, prioritizing and determining the need for system improvements. These processes are supported by the integral role of other waiver partners in providing data, analyzing data, trending and formulating recommendations for system improvements. These partners include the case managers, providers, participants, LAH Waiver Advisory Committee members and Waiver Quality Council members.

When data analysis reveals the need for system change, ideas for system change are developed by LAH staff. Implementation plans developed as a result of this process will be shared with stakeholders primarily through the forum of the LAH Waiver Advisory Committee. Input and recommendations regarding changes to the waiver design are invited from stakeholders.

Depending on the nature of design changes, data analysis and plans will also be presented to the Waiver Quality Council for review and recommendations. There may be circumstances when system improvement plans originate in the Waiver Quality Council because there are over-arching design changes indicated that impact all or some of Maryland's HCBS waivers.

- ii. System Improvement Activities

Responsible Party (check each that applies):	Frequency of Monitoring and Analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

<input checked="" type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The LAH utilizes multiple methods to monitor and analyze the effectiveness of system design changes. Monitoring the effectiveness of the system design changes is an ongoing process performed Stakeholders also provide a valuable role in providing feedback and in analyzing the results of system change. The primary stakeholder group is the LAH Waiver Advisory Committee which meets three to four times a year. Stakeholders provide valuable input that facilitates assessment of the effectiveness of system changes.

Additionally, each waiver presents system design changes and evaluation information to the Waiver Quality Council. Feedback is received from council members regarding the design changes and the results of the evaluation of effectiveness. Council members also share their experiences in monitoring and analyzing system design changes in Maryland's other waivers. The Waiver Quality Council, which meets quarterly, will provide ongoing feedback as monitoring reveals issues that should be brought before the Council. The Waiver Quality Council aggregates, tracks and trends quarterly Reportable Event data from the various waivers. This could result in overarching design changes involving all or some of Maryland's waivers. The Council would monitor and evaluate these changes through data presented to the Council by members representing individual waivers.

Analysis of Reportable Event data, service coordinator monitoring and provider monitoring are used on an ongoing basis to evaluate the effectiveness of system design changes in addition to the methods previously covered.

Monitoring the effectiveness of system design changes is an on-going process performed predominantly by MSDE staff who are responsible for the administration of the waiver and for ensuring an effective, dynamic quality management plan. Stakeholders also have a definite role in providing input to MSDE regarding plans for system design changes. As a logical extension of that role, stakeholders would also be involved in analyzing the results of changes made to the design of the Autism Waiver. These processes will be central to the guiding purpose of the Autism Waiver Advisory Council and the Autism Waiver Provider Focus Group. Parent focus groups have also been convened for this purpose. Again, waiver design changes will be examined at the DHMH-MSDE Interagency meetings, and will always be presented to the Waiver Quality Council for input and direction as appropriate. They will also be shared with families, service coordinators, and providers through mailings and trainings. The Towson State University Autism Waiver and Family Quality of Life Survey is another strategy utilized for monitoring the effectiveness of system design changes.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The effectiveness of the Quality Improvement Strategy will be evaluated on a bi-annual basis utilizing data resulting from various system design changes. The evaluation will involve the LAH waiver Deputy Director of Long-Term Care and Waiver Services, the LAH Division Chief, Program Manager, the Quality Manager. Results of Quality Improvement evaluations will be compiled in the annual report for the program beginning in March 2010. The report will also be shared with the Waiver Quality Council and the LAH Advisory Committee for input and feedback.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

(a) There are no requirements for the independent audit of providers.

(b)(c) There is an annual independent audit of Maryland's Medical Assistance Program that includes Medicaid home and community-based waiver programs. The annual audit is conducted by an independent contractor in accordance with Circular A-133. A major focus of this audit is the integrity of provider billings. The contract for this audit is bid out every five years by Maryland's Comptroller's Office. The present contractor is Abrams, Foster, Nole and Williams.

The Maryland Department of Legislative Services conducts independent audits of all State agencies and programs including the Medical Assistance Program. Medicaid is audited on a two-year cycle.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Numerator: Total number of paid claims; Denominator: Total number of total claims received.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check	Frequency of data collection/generation (check	Sampling Approach (check each that applies):
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<i>each that applies):</i>	<i>each that applies):</i>	
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input checked="" type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. Fiscal intermediary services are provided to waiver participants using the non-agency or consumer model of attendant care services. The fiscal intermediary acts as the payroll agent on behalf of these participants; in this capacity, the fiscal intermediary is responsible for issuing bi-weekly provider payroll checks, collecting and paying federal and state tax withholding and unemployment insurance, as well as securing and maintaining workers' compensation insurance policies. The fiscal intermediary assists new participant employers in obtaining an Employment Identification Number from the Internal Revenue Service. The fiscal intermediary collects mandatory employee documentation including the social security number, documents to support the I-9 form, and the IRS W-4 form. The fiscal intermediary invoices LAH an administrative fee for their services and is reimbursed for the Medicaid provider wages, taxes and workers' compensation. The contract is monitored by the Agency Budget Specialist in the Living at

Home Waiver Division. The Fiscal Intermediary Contract is monitored by the Agency Budget Specialist in the LAH waiver. The Fiscal Intermediary contract requires the vendor to submit deliverables monthly and quarterly to the LAH program.

Provider claims are submitted to LAH for payment. The claims are entered into electronic billing system by Medical Care Program Specialist (MCPS). All claims are matched against the approved plan of service. The Agency Budget Specialist supervises the MCPSs and checks the entered claims each day. The claims are then submitted electronically to MMIS for payment. After the claims are paid an adjudicated report is generated from MMIS and given to the Agency Budget Specialist who reviews and makes the necessary corrections on unpaid claims.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

In addition, staff monitor all claims paid by this contract through a continuous and ongoing internal process. Annually, the contractor is required to submit the results of a customer satisfaction survey conducted by a third party entity. In addition, the contractor is required to submit documentation to the agency regarding compliance with procurement regulations and requirements.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input checked="" type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

☒ No

☐ Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Rate increases are determined based on established regulations. Program rates automatically increase on July 1 of each year beginning July 1, 2009, by the lesser of: 2.5 percent; or the change from march to march in the medical care component of the Consumer Price index for all urban consumers (CPI-U) for the Washington-Baltimore area. This amount may be reduced based on budgetary restrictions.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Waiver claims are paid by one of three methods. 1. For non-Agency attendant care services, the provider sends claims to the contracted fiscal intermediary who acts as the participant employer's payroll agent. This third party entity sends bi-weekly payroll payments to the providers after withholding appropriate taxes. The fiscal intermediary pays claims based on authorization information provided by LAH via the tracking system and invoices the program for reimbursement. The fiscal intermediary sends batches of claims to the Living at Home Waiver program; claims are adjudicated and sent through the Medicaid Management Information System.

2. Claims for all waiver services, with the exception of non-agency attendant care services and Medical Day Care Services, are processed in the Living at Home Waiver Division.

3. Claims for Medical Day Care Program services provided via the Living at Home Waiver Program flow directly from the provider to the State's payment system. The Living at Home Waiver program plans to use the participant Medical Day Care Program authorization form as a means to audit service delivery and recover applicable funds.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (*select one*):

- ☒ **No. State or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51 (b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The Living at Home Waiver Program fiscal unit is responsible for entering information from service plans into a database, reviewing claims, and entering claims into the electronic billing system. After the claims are given a final review, they are transmitted into the Medicaid Management Information System in order for payments to be rendered to providers and the federal financial participation to be paid.

Upon enrollment into the Living at Home Waiver Program, participant file, including the approved plan of service, is forwarded to the fiscal unit. The fiscal clerks enter demographic information, the Medicaid number, the date of entry into the program, and the dates for which individual providers are authorized to be paid for waiver services. Claims for services rendered by other providers or for dates not included in the authorized plan of service cannot be paid. In the event that a participant has chosen to modify their plan of service, the case manager submits an updated plan of service inclusive of any changes. When this information is submitted to the Living at Home Program, it is forwarded to the fiscal unit and the plan of service information is updated.

The Living at Home Waiver Program fiscal unit receives DHMH 248 claims forms and provider service records for attendant care providers. In order for payment to be rendered to the provider, the participant must sign or initial for each date of service and also sign the bottom of the form to verify that services were completed. In addition, the contracted case management agency is required to follow up with participants, during monthly contacts and quarterly face-to-face visits, about any service interruptions.

For transition service claims, the provider must submit a receipt for the items purchased in addition to the invoice and DHMH 248.

In addition, the LAH provider audits include a review of all documentation that has been received. The Medicaid Management Information System provides additional safeguards by rejecting claims for providers whose enrollment is suspended or terminated and for participants whose program eligibility has ended.

When individuals are disenrolled from the program, LAH staff notifies the fiscal unit of the end date for program services.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (*select one*):**

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a**

monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☒ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

A fiscal intermediary service is used for payments to providers of non-agency attendant care providers. The fiscal intermediary compares timesheets to authorized units before rendering payment.

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- ☒ **No. The State does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ☒ **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- ☐ **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

- e. Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ☒ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ☐ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- ☐ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

- f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- ☒ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- ☐ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ☒ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ☒ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- ☒ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☒ This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

- ☒ **Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.
☐ **Applicable**

Check each that applies:

- ☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

- ☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

☒ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☐ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

☒ **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who**

resides in the same household as the participant.

- ☒ **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- ☒ **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**
 - i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**
- ii. Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)****a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- ☒ **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ☐ **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

--

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)

1	44947.37	4908.26	49855.63	45695.56	8968.49	54664.05	4808.42
2	47118.82	5031.70	52150.52	47523.39	9237.55	56760.94	4610.42
3	49464.75	5150.48	54615.23	49424.57	9514.80	58939.37	4324.14
4	51493.91	5283.38	56777.29	51401.82	9800.36	61202.18	4424.89
5	52471.12	5417.51	57888.63	53458.16	10094.50	63552.66	5664.03

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	
		Nursing Facility	
Year 1	765		765
Year 2	850		850
Year 3	944		944
Year 4 (renewal only)	1047		1047
Year 5 (renewal only)	1162		1162

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was derived from historical program data for Living at Home Waiver participants. Medicaid Management Information System data, electronic billing system data and reportable events inform the waiver about dates in which waiver participants are not eligible for waiver services due to program ineligibility, hospitalization, or re-entry into a nursing facility for 30 or more days. The average length of stay has been calculated on the total days of waiver coverage divided by the average per capita of waiver expenditures as reported on the CMS 372 (S) Lag Report, Reporting Period 7/1/06 – 6/30/07.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.
- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

These numbers are derived from historical program data over the previous five years. Data is made available through the Medicaid Management Information System and the Electronic Billing System. Usage trends for individual services were projected by identifying annual percentages of increases or decreases per service across all participants. New waiver services, including Environmental Assessments, Home Delivered Meals, as well as Dietician and Nutrition Services were projected based on usage data from the Waiver for Older Adults. Usage projections for Case Management are based on the administrative invoices previously paid by LAH. Medical Day Service projections are based on previous use as a State Plan service. Family Service usage increases have been incorporated into these projections in order to allow paid family attendant care providers to receive training required to become a Medication Technician in accordance with Maryland Board of Nursing requirements.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These numbers are derived from historical program data available through the Medicaid Management Information System. These figures have been stable with the exception of a decrease in cost due to implementation of Medicare Part D as noted on the 2007 372 Lag Report. Approximately 45% of LAH participants are dual eligible and decreases have been incorporated into D' projections. Additional decreases in D' costs are projected based on Adult Medical Day Program being offered as a waiver service that is captured in Factor D.

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These estimates are derived from data obtained through the Medicaid Management Information System about nursing facility users during FY 2008.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

These estimates are derived from data obtained through the Medicaid Management Information System about nursing facility users during FY 2008.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services
Consumer Training
Personal Emergency Response System-Monitoring
Home Delivered Meals
Dietitian Nutrition Services
Initial and Ongoing Case Management Services
Medical Day Care
Nursing Supervision
Environmental Accessibility Adaptation
Non-Agency Family Training
Non-Agency Nursing Supervision
Family Training
Attendant Care
Environmental Assessment
Assistive Technology
Personal Emergency Response System-Purchase
Transition Services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Training Total:							162.72
Consumer Training	<input type="checkbox"/>	4	2	2.00	40.68	162.72	
Personal Emergency Response System-Monitoring Total:							260280.00
Personal Emergency Response System-Monitoring	<input type="checkbox"/>	5784	482	12.00	45.00	260280.00	
Home Delivered Meals Total:							160512.00
Home Delivered Meals	<input type="checkbox"/>	27324	44	640.00	5.70	160512.00	
Dietitian Nutrition Services Total:							10036.80
Dietitian Nutrition Services	<input type="checkbox"/>	120	20	8.00	62.73	10036.80	
Initial and Ongoing Case Management Services Total:							2919240.00
Initial and Ongoing Case Management Services	<input type="checkbox"/>	263160	765	288.00	13.25	2919240.00	
Medical Day Care Total:							900467.40
Medical Day Care	<input type="checkbox"/>	12180	58	210.00	73.93	900467.40	
Nursing Supervision Total:							350395.50
Nursing Supervision	<input type="checkbox"/>	27648	595	15.00	39.26	350395.50	
Environmental Accessibility Adaptation Total:							293265.00
Environmental Accessibility Adaptation	<input type="checkbox"/>	147	147	1.00	1995.00	293265.00	
Non-Agency Family Training Total:							861.76
Non-Agency Family Training	<input type="checkbox"/>	32	2	16.00	26.93	861.76	
Non-Agency Nursing Supervision Total:							17773.80
Non-Agency Nursing Supervision	<input type="checkbox"/>	3168	66	10.00	26.93	17773.80	
Family Training Total:							12563.20
Family Training	<input type="checkbox"/>	320	20	16.00	39.26	12563.20	

Attendant Care Total:							29021840.45
Non-Agency Attendant Care	<input type="checkbox"/>	995835	481	1661.00	13.45	10745756.45	
Agency Attendant Care	<input type="checkbox"/>	1063800	591	1800.00	17.18	18276084.00	
Environmental Assessment Total:							8781.52
Environmental Assessment	<input type="checkbox"/>	20	22	1.00	399.16	8781.52	
Assistive Technology Total:							136616.22
Assistive Technology	<input type="checkbox"/>	169	169	1.00	808.38	136616.22	
Personal Emergency Response System-Purchase Total:							4644.00
Personal Emergency Response System-Purchase	<input type="checkbox"/>	86	86	1.00	54.00	4644.00	
Transition Services Total:							287300.00
Transition Services	<input type="checkbox"/>	169	169	1.00	1700.00	287300.00	
GRAND TOTAL: Total: Services included in capitation: Total: Services not included in capitation: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Services included in capitation: Services not included in capitation: Average Length of Stay on the Waiver:							34384740.37 34384740.37 765 44947.37 44947.37 325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Training Total:							330.32
Consumer Training	<input type="checkbox"/>	4	4	2.00	41.29	330.32	
Personal Emergency Response System-Monitoring Total:							282555.00
Personal Emergency Response System-Monitoring	<input type="checkbox"/>	5784	546	11.50	45.00	282555.00	
Home Delivered Meals Total:							170457.60

Home Delivered Meals	<input type="checkbox"/>	29440	46	640.00	5.79	170457.60	
Dietitian Nutrition Services Total:							12734.00
Dietitian Nutrition Services	<input type="checkbox"/>	200	25	8.00	63.67	12734.00	
Initial and Ongoing Case Management Services Total:							3292560.00
Initial and Ongoing Case Management Services	<input type="checkbox"/>	131250	850	288.00	13.45	3292560.00	
Medical Day Care Total:							945504.00
Medical Day Care	<input type="checkbox"/>	12180	60	210.00	75.04	945504.00	
Nursing Supervision Total:							420816.00
Nursing Supervision	<input type="checkbox"/>	27648	704	15.00	39.85	420816.00	
Environmental Accessibility Adaptation Total:							323190.00
Environmental Accessibility Adaptation	<input type="checkbox"/>	162	162	1.00	1995.00	323190.00	
Non-Agency Family Training Total:							7871.04
Non-Agency Family Training	<input type="checkbox"/>	48	18	16.00	27.33	7871.04	
Non-Agency Nursing Supervision Total:							23230.50
Non-Agency Nursing Supervision	<input type="checkbox"/>	3168	85	10.00	27.33	23230.50	
Family Training Total:							11476.80
Family Training	<input type="checkbox"/>	320	18	16.00	39.85	11476.80	
Attendant Care Total:							34095548.40
Non-Agency Attendant Care	<input type="checkbox"/>	890296	536	1661.00	13.65	12152540.40	
Agency Attendant Care	<input type="checkbox"/>	1258200	699	1800.00	17.44	21943008.00	
Environmental Assessment Total:							8913.08
Environmental Assessment	<input type="checkbox"/>	22	22	1.00	405.14	8913.08	
Assistive Technology Total:							163216.00
Assistive Technology	<input type="checkbox"/>	202	202	1.00	808.00	163216.00	
Personal Emergency Response System-Purchase Total:							5292.00
Personal Emergency Response System-Purchase	<input type="checkbox"/>	98	98	1.00	54.00	5292.00	
Transition Services Total:							287300.00
Transition Services	<input type="checkbox"/>	169	169	1.00	1700.00	287300.00	
GRAND TOTAL:							40050994.74
Total: Services included in capitation:							
Total: Services not included in capitation:							40050994.74
Total Estimated Unduplicated Participants:							850
Factor D (Divide total by number of participants):							47118.82

Services included in capitation:

Services not included in capitation:

47118.82

Average Length of Stay on the Waiver:

325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Training Total:							502.92
Consumer Training	<input type="checkbox"/>	6	6	2.00	41.91	502.92	
Personal Emergency Response System-Monitoring Total:							320332.50
Personal Emergency Response System-Monitoring	<input type="checkbox"/>	5784	619	11.50	45.00	320332.50	
Home Delivered Meals Total:							187840.00
Home Delivered Meals	<input type="checkbox"/>	27324	50	640.00	5.87	187840.00	
Dietitian Nutrition Services Total:							15511.20
Dietitian Nutrition Services	<input type="checkbox"/>	120	30	8.00	64.63	15511.20	
Initial and Ongoing Case Management Services Total:							3711052.80
Initial and Ongoing Case Management Services	<input type="checkbox"/>	131250	944	288.00	13.65	3711052.80	
Medical Day Care Total:							1039584.00
Medical Day Care	<input type="checkbox"/>	12180	65	210.00	76.16	1039584.00	
Nursing Supervision Total:							504209.25
Nursing Supervision	<input type="checkbox"/>	27648	831	15.00	40.45	504209.25	
Environmental Accessibility Adaptation Total:							355110.00
Environmental Accessibility Adaptation	<input type="checkbox"/>	178	178	1.00	1995.00	355110.00	
Non-Agency Family Training Total:							7989.12
Non-Agency Family Training	<input type="checkbox"/>	160	18	16.00	27.74	7989.12	
Non-Agency Nursing Supervision Total:							26075.60

Non-Agency Nursing Supervision	<input type="checkbox"/>	3168	94	10.00	27.74	26075.60	
Family Training Total:							11649.60
Family Training	<input type="checkbox"/>	320	18	16.00	40.45	11649.60	
Attendant Care Total:							40014128.70
Non-Agency Attendant Care	<input type="checkbox"/>	995835	595	1661.00	13.86	13697768.70	
Agency Attendant Care	<input type="checkbox"/>	1063800	826	1800.00	17.70	26316360.00	
Environmental Assessment Total:							12336.30
Environmental Assessment	<input type="checkbox"/>	30	30	1.00	411.21	12336.30	
Assistive Technology Total:							195108.78
Assistive Technology	<input type="checkbox"/>	241	241	1.00	809.58	195108.78	
Personal Emergency Response System-Purchase Total:							5994.00
Personal Emergency Response System-Purchase	<input type="checkbox"/>	86	111	1.00	54.00	5994.00	
Transition Services Total:							287300.00
Transition Services	<input type="checkbox"/>	169	169	1.00	1700.00	287300.00	
GRAND TOTAL:							46694724.77
Total: Services included in capitation:							
Total: Services not included in capitation:							46694724.77
Total Estimated Unduplicated Participants:							944
Factor D (Divide total by number of participants):							49464.75
Services included in capitation:							
Services not included in capitation:							49464.75
Average Length of Stay on the Waiver:							325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4 (renewal only)

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Training Total:							680.64
Consumer Training	<input type="checkbox"/>	16	8	2.00	42.54	680.64	
Personal Emergency							

Response System-Monitoring Total:							378540.00
Personal Emergency Response System-Monitoring	<input type="checkbox"/>	8412	701	12.00	45.00	378540.00	
Home Delivered Meals Total:							209792.00
Home Delivered Meals	<input type="checkbox"/>	35200	55	640.00	5.96	209792.00	
Dietitian Nutrition Services Total:							19942.40
Dietitian Nutrition Services	<input type="checkbox"/>	304	38	8.00	65.60	19942.40	
Initial and Ongoing Case Management Services Total:							4179288.96
Initial and Ongoing Case Management Services	<input type="checkbox"/>	301536	1047	288.00	13.86	4179288.96	
Medical Day Care Total:							1136457.00
Medical Day Care	<input type="checkbox"/>	14700	70	210.00	77.31	1136457.00	
Nursing Supervision Total:							584962.50
Nursing Supervision	<input type="checkbox"/>	13935	950	15.00	41.05	584962.50	
Environmental Accessibility Adaptation Total:							391020.00
Environmental Accessibility Adaptation	<input type="checkbox"/>	196	196	1.00	1995.00	391020.00	
Non-Agency Family Training Total:							8110.08
Non-Agency Family Training	<input type="checkbox"/>	288	18	16.00	28.16	8110.08	
Non-Agency Nursing Supervision Total:							29568.00
Non-Agency Nursing Supervision	<input type="checkbox"/>	920	105	10.00	28.16	29568.00	
Family Training Total:							11822.40
Family Training	<input type="checkbox"/>	288	18	16.00	41.05	11822.40	
Attendant Care Total:							46448295.60
Non-Agency Attendant Care	<input type="checkbox"/>	1096260	660	1661.00	14.06	15413415.60	
Agency Attendant Care	<input type="checkbox"/>	1728000	960	1800.00	17.96	31034880.00	
Environmental Assessment Total:							14608.30
Environmental Assessment	<input type="checkbox"/>	35	35	1.00	417.38	14608.30	
Assistive Technology Total:							233216.64
Assistive Technology	<input type="checkbox"/>	288	288	1.00	809.78	233216.64	
Personal Emergency Response System-Purchase Total:							7722.00
Personal Emergency Response System-Purchase	<input type="checkbox"/>	143	143	1.00	54.00	7722.00	
Transition Services Total:							260100.00
Transition Services						260100.00	

<input type="checkbox"/>	153	153	1.00	1700.00		
GRAND TOTAL:						53914126.52
Total: Services included in capitation:						
Total: Services not included in capitation:						53914126.52
Total Estimated Unduplicated Participants:						1047
Factor D (Divide total by number of participants):						51493.91
Services included in capitation:						
Services not included in capitation:						51493.91
Average Length of Stay on the Waiver:						325

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5 (renewal only)

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Training Total:							863.60
Consumer Training	<input type="checkbox"/>	20	10	2.00	43.18	863.60	
Personal Emergency Response System-Monitoring Total:							438480.00
Personal Emergency Response System-Monitoring	<input type="checkbox"/>	9744	812	12.00	45.00	438480.00	
Home Delivered Meals Total:							255552.00
Home Delivered Meals	<input type="checkbox"/>	35200	66	640.00	6.05	255552.00	
Dietitian Nutrition Services Total:							23436.16
Dietitian Nutrition Services	<input type="checkbox"/>	352	44	8.00	66.58	23436.16	
Initial and Ongoing Case Management Services Total:							4705263.36
Initial and Ongoing Case Management Services	<input type="checkbox"/>	334656	1162	288.00	14.06	4705263.36	
Medical Day Care Total:							1235902.50
Medical Day Care	<input type="checkbox"/>	15750	75	210.00	78.47	1235902.50	
Nursing Supervision Total:							646926.75
Nursing Supervision	<input type="checkbox"/>	15210	1035	15.00	41.67	646926.75	
Environmental Accessibility Adaptation Total:							430920.00
Environmental Accessibility						430920.00	

Adaptation	<input type="checkbox"/>	216	216	1.00	1995.00		
Non-Agency Family Training Total:							8231.04
Non-Agency Family Training	<input type="checkbox"/>	288	18	16.00	28.58	8231.04	
Non-Agency Nursing Supervision Total:							34296.00
Non-Agency Nursing Supervision	<input type="checkbox"/>	1200	120	10.00	28.58	34296.00	
Family Training Total:							13334.40
Family Training	<input type="checkbox"/>	288	20	16.00	41.67	13334.40	
Attendant Care Total:							52548430.92
Non-Agency Attendant Care	<input type="checkbox"/>	1215852	749	1661.00	14.28	17765590.92	
Agency Attendant Care	<input type="checkbox"/>	1850400	1060	1800.00	18.23	34782840.00	
Environmental Assessment Total:							17792.88
Environmental Assessment	<input type="checkbox"/>	41	42	1.00	423.64	17792.88	
Assistive Technology Total:							278750.08
Assistive Technology	<input type="checkbox"/>	344	344	1.00	810.32	278750.08	
Personal Emergency Response System-Purchase Total:							10260.00
Personal Emergency Response System-Purchase	<input type="checkbox"/>	190	190	1.00	54.00	10260.00	
Transition Services Total:							323000.00
Transition Services	<input type="checkbox"/>	190	190	1.00	1700.00	323000.00	
GRAND TOTAL:							60971439.69
Total: Services included in capitation:							60971439.69
Total: Services not included in capitation:							1162
Total Estimated Unduplicated Participants:							52471.12
Factor D (Divide total by number of participants):							52471.12
Services included in capitation:							52471.12
Services not included in capitation:							
Average Length of Stay on the Waiver:							325